SEPTEMBER • OCTOBER 1962

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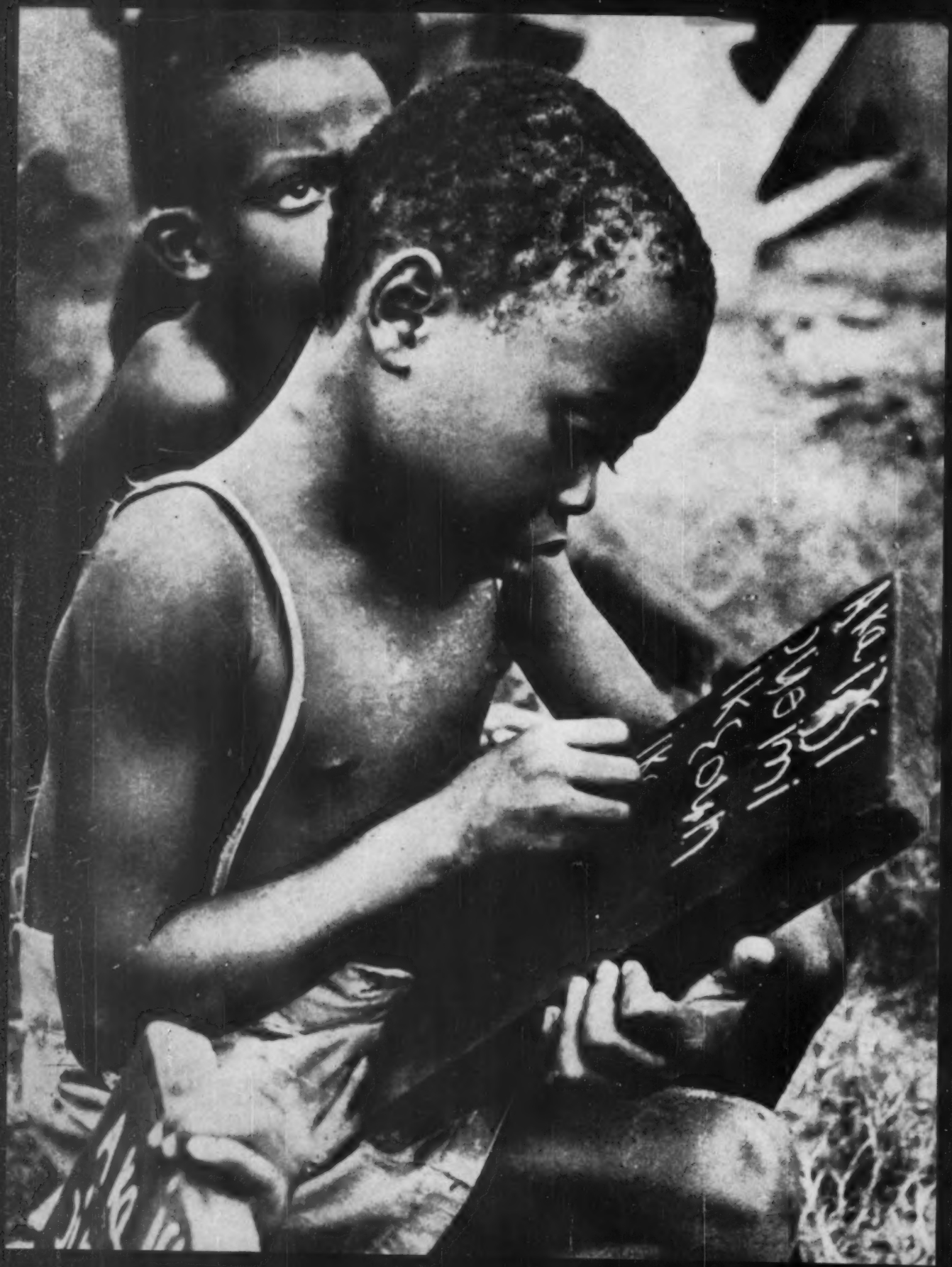
AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Assistance to Other Cultures

Parents of the Retarded

Foster Care of Delinquents

Informing Parents of Defects



AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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LEARNING is a serious business for children all over the world, as the concentration of this child suggests; and in the developing countries of Africa it has become almost a passion. How UNICEF is helping such countries to meet the educational expectations of their people is described on page 200 of this issue.

The photo is from the book, "Incredible Africa," recently published by the John Day Co., Inc.

◀ *the authors*

Dr. Derrick B. Jelliffe (left) received his medical training at London University and has graduate diplomas in child health and tropical medicine. He has been on the medical faculties of universities in the West Indies, India, Nigeria, and the United States as well as in Uganda. Dr. F. John Bennett (right), who received his medical and public health training at the South African universities of Cape Town and Witwatersrand, has held public health positions in Cape Town, Worcester, Basutoland, and Natal, South Africa.

Among the various tasks Alice V. Anderson has carried out in her 25 years of social work has been the conducting of orientation group meetings for mentally ill patients at St. Elizabeths Hospital in Washington, D.C.—an experience not unlike her work with groups of parents at the D.C. Clinic for Retarded Children, whose staff she joined 3 years ago. With a master's in social work from Howard University, she has also worked as a child welfare consultant in Korea.

In addition to supervising the program for delinquent girls she describes in her article, Elizabeth V. Hunt has responsibility for her agency's adoption program. Her entire career since she entered the welfare field during the depression of the 1930's has been in public welfare, with the focus, since 1943, on child welfare. With her master's in social work from the University of Minnesota, she has served as clinical field instructor for graduate students from the university's school of social work.

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For more than 20 years before moving to Phoenix in early 1961, Dr. Irene M. Josselyn practiced psychiatry and psychoanalysis in Chicago, where she also was on the staff of the Chicago Institute for Psychoanalysis for 11 years, and served as consultant to a variety of social agencies. At present she carries on a private practice, edits the *Journal of the American Academy of Child Psychiatry*, and serves as consultant to a veterans' hospital.

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Helping the developing countries to build up maternal and child health services means finding solutions to . . .

CULTURAL PROBLEMS IN TECHNICAL ASSISTANCE

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OF THE NUMEROUS definitions of "culture," we tend to use one which fits our thesis best. In this article we use the word to refer to the whole way of life of a group of people—including the artifacts produced; the adaptation to the environment; the shared mosaic of belief, feeling, and behavior; and the patterns of relationship between individuals.

Many of the cultural problems of giving technical aid in the field of maternal and child health in developing regions arise from the donor's Western-based scientific cultural conditioning rather than from the recipient culture.[1-3] In tropical countries these problems arise in connection with five major aspects of maternal and child health, or as we usually say, MCH work:

1. The evaluation of the country's health problems and the establishment of health statistics.

2. The provision and training of personnel.

3. The organization and operation of maternal and child health services.

4. Nutrition education.

5. Health education.

In most underdeveloped countries there are no accurate vital statistics relating to illness and death among mothers and children. Usually even census figures, showing the proportion of children of different ages in the population, are not available. The maternal and child health worker is thus faced with an imperfect knowledge of his major problems and no baseline from which to gauge progress. Moreover, he lacks one of the most effective weapons for overcoming public and administrative inertia.

One of the commonest difficulties in carrying out a census in newly developing countries lies in the fact that many people do not like to have their children counted. This reluctance is sometimes due to a general mistrust of strangers, sometimes to a suspicion that the process is related to tax registration, and sometimes, as among the Baganda in Africa, that it is tempting providence to draw attention to family size. At Makerere College Health Center in Uganda, it has taken over 2 years to obtain an approximate census of a relatively small area. The process was additionally handicapped by the lack of villages or groupings of dwellings in the area, and by the local custom of sending children to live with relatives, who maintain they are their own.

In many developing regions, as among the Zulus, the maintenance of census figures around a health center is further hampered by the continuous movement of men, women, and children between towns and rural areas. Similar problems are present to an

even greater extent among such nomadic peoples as the Karamojong cattle raisers of Uganda or the Hadza hunters of northern Tanganyika.

Attempts to receive notification of births, deaths, and illnesses may also meet with little success owing to a general fear that the information might be used for ulterior motives, especially taxation, and also because of local concepts of the cause and significance of these events. For example, death of a newborn may be considered a result of a mother's promiscuity, and so a cause of shame which should not be revealed.

Inaccuracies in health statistics may also result from a variety of other cultural concepts and practices. In some communities, births, and in others deaths, are accompanied by much obvious ceremonial, which may lead to overreporting on the part of field observers. In parts of southeast Asia problems arise from the belief that the death of a baby is of little consequence since he had not yet been initiated into his community, and to the superstition that it is inauspicious to reveal the name or sex of a newborn.[4]

Rituals, Taboos, and Disease

Hospital statistics in some underdeveloped areas may be subject to even greater bias because people believe that certain diseases are not amenable to modern scientific medicine, and, therefore, do not present themselves for treatment. For example, among the Zulus, important communicable diseases, such as tuberculosis and syphilis, are thought to be forms of poisoning and bewitchment, best treated by indigenous practitioners. Especially where concepts of causation include the transgression of social taboos are people likely to think that such diseases only occur among themselves and, therefore cannot be understood or treated by the foreign-trained.

Statistical bias can also occur in hospital and clinic practice in relation to certain age groups. Thus, in New Guinea, the incident of neonatal tetanus seemed to be much less than might have been expected. This, however, was not because the disease was not widespread, but because mothers and newborns were kept in ritual postnatal seclusion during which many babies died without ever being seen.[5] Similar situations probably exist elsewhere, as in India where postnatal seclusion is customary.

Yet another factor making precise diagnosis and hence precise statistics hard to achieve in hospital work, particularly in Moslem societies, is the great difficulty in obtaining autopsies, especially on children. Moreover, in most tropical countries where the fear of witchcraft is widespread, the removal of pathological specimens at post mortems is viewed with much suspicion. The use of human tissue, whether nails, hair, or flesh, is a basic maneuver in many magical processes, such as the potent *borfima* (charm) of the Leopard Men of Sierra Leone, an essential ingredient of which is human omental fat.

Much so-called "buried disease" exists among children in the tropics including illnesses that do not reach the attention of the pediatrician, who is apt to be preoccupied with the constant battle against such overwhelming problems as protein-calorie malnutrition and diarrheal disease. Even Western-labeled "behavior problems" may occur, but, as they are not recognized as constituting problems at all in a different cultural nexus, they are not reported. Since bed wetting among Baganda children is a source of pride, as it portends great fertility and potency, a Baganda peasant mother would certainly not consider it as something to mention to the doctor. Nevertheless, it might occur under exactly the same conditions as in European and American children.

In spite of these difficulties, prevalence studies are extremely helpful for the MCH worker in an underdeveloped country, for they not only acquaint him with the relative commonness of disease in the community itself, but also help him learn something of the causative environmental and cultural factors responsible. Surveys of this type, in which students participate as "teaching safaris," [6] are carried out by the Departments of Child Health and of Preventive Medicine at Makerere Medical School as a continuing series of community studies in child health in east Africa.[7]

Certain maneuvers employed in such field studies may create difficulties because of cultural misinterpretation. The sucking up of blood into a pipette to obtain a specimen may be thought to be blood drinking for magical reasons, an idea that is reinforced if the staff member concerned is a woman wearing red lipstick. Again the weighing of children may be regarded as tempting providence, or the collection of stool specimens feared, lest they be used for bewitchment.

Wherever a high incidence of some particular disease is discovered, whether by survey or by clinic notification, it is, of course, necessary for applying preventive measures logically to determine etiologic "molding forces." These often lie as much in the field of human behavior as in the environment alone. Before attempting the investigation of etiologic factors, the MCH worker must acquire as much knowl-

edge as possible of the local culture pattern. Otherwise he will have little idea even where to begin to seek the complex factors making up the mosaic of causation. Hours spent on reading anthropological literature and on discussions with local people about their lives are, in fact, hours spent on gaining medical insight.

Only after such preliminary exploration can the form, scope, and aims of technical aid in MCH programs best be determined and deployed. In fact, an evaluation of problems and their causes is a most urgent research project for developing countries.

Orientation courses conducted by anthropologists, sociologists, and members of the recipient community could well form part of the training of new foreign recruits to underdeveloped areas.

Provision and Training of Personnel

Foreign personnel often work with many disadvantages which prevent them from being as valuable to a country lacking technical experts as they otherwise might be. In Africa, for example, many foreign workers have personal feelings of not belonging, of being unable to identify themselves with the people for whom they are working, or of disillusionment arising from their discovery of the hugeness of some of the problems the countries face and of the smallness of any immediate contribution that they themselves can make.

One of the greatest problems in technical assistance is the language barrier. Without knowledge of the local language, the MCH worker is always one step removed from his patient. Yet few consultants can spare the time to learn one or more new languages while, at the same time, having to learn so much else about the local situation and to deal with the flood of other problems inherent in their work.

To overcome the handicap of his foreignness, the technical assistant must adjust himself as quickly as possible to the culture and society in which he is working. He must make genuine friends among the local people and must try to cast off the blinders imposed by his own culture. He must rid himself of the "Jehovah complex"—the feeling that he unaided can make immense improvements—and must realize that his greatest contribution will be in the degree to which he stimulates the local population to recognize and solve their own problems, and to which he encourages and teaches local colleagues.

The training of local personnel to carry out maternal and child health work is a top priority of technical aid programs in underdeveloped countries. The tutors are often foreigners or local persons who have been trained overseas. Above all they should not teach out of their foreign culture, but should clothe the scientific bones of their instruction with flesh and muscle of the local culture pattern. Often one still finds locally trained workers repeating the "orange juice and bottle-feeding" information that they have unnecessarily and dangerously been taught.[8]

In most developing areas, there are available little money, few teachers, and very few candidates with suitable basic qualifications for training to the professional level. Auxiliaries, therefore, have to be trained at lower levels to supplement the work of the few professional workers. The relationship between professional and auxiliary must be both supervisory and advisory—the greater the gap in qualifications, the more emphasis being placed on supervision. Many foreign professionals, however, have never worked with auxiliaries, and teamwork suffers as a consequence. Training often has to be radically different than in the teacher's own country and material for teaching, including textbooks, may have to be prepared for the local culture, perhaps even in the vernacular.[9]

The selection and stimulation of local individuals to specialize in pediatrics, once regarded simply as

Student midwives in Kuching, Sarawak, feeding a newborn infant. Bottle feeding is supplanting breast feeding in this community, although families rarely have the kind of refrigeration that protects the baby's formula from bacterial contamination.

procedures of providing scholarships to Britain, the United States of America, or elsewhere, are not so simple when viewed from within the country concerned.[6] Does postgraduate training in a highly advanced country equip a person suitably for tackling problems which may have their origin in a cassava and plantain diet? Is not higher education in Europe and America too bound up in Western culture to fit the MCH worker for practice in a totally different society?

The contribution of modern scientific training to the personnel problems of the tropics would be much greater if attention were paid to variations among cultures and societies.

MCH Services

Antenatal care in many societies consists of the use of medicines to prevent the fetus from being harmed by bewitchment or other noxious influences; and of the observance of certain rituals and taboos.[10] Sometimes these practices may be directly harmful in themselves; more frequently they exert an indirect deleterious effect by preventing the mother from seeking modern antenatal care.

Scientific maternity care, no matter how well distributed, may have little appeal to people if it does not cater to traditional beliefs, such as those regarding importance of the way the umbilical cord is cut or the disposal of the placenta. In some societies the person conducting the delivery has traditional duties in connection with the care of the home or of the mother during her period of ritual seclusion, which a foreign-trained midwife does not fulfill. Scientific midwifery, therefore, in its techniques, its equipment, and its personnel, may be at variance with local customs and traditions, and unless it can make the necesssary adjustments it will be unlikely to be fully utilized.

Some seemingly trivial customs in the immediate postnatal period can have far-reaching consequences. In some societies the tradition of placing cow dung on the baby's umbilical stump is responsible for a high incidence of neonatal tetanus. In others, failure to tie the cord, common among the Baganda, results in hemorrhage and neonatal anemia in the newborn, necessitating emergency transfusion. Understanding of such dangers has to be transmitted through health education to expectant mothers who are going to be delivered at home and through the training courses to the midwives.

In the care of premature babies, special attention has to be paid to keeping up lactation, for failure of the mother to produce breast milk is usually a death sentence for a baby among poor people in tropical regions[11] where hygienic bottle feeding is almost impossible to achieve. Difficulties can arise if the person in charge of a premature unit does not understand the need to encourage mothers to express breast milk until their infants can suckle for themselves.

Infant welfare clinics can rarely limit their clientele to well babies in tropical areas where a procession of sicknesses of one degree or another is the fate of the majority of young children. Failure to understand this is a common Western-based cultural difficulty in MCH assistance, as many workers have tried to make their clinics approximate the streamlined weighing, counseling, and immunizing sessions of North America and Europe.

Tropical hospitals usually have to make arrangements for the admission of a mother with her child. This represents an extremely valuable opportunity for health education and is, of course, imperative for the continued breast feeding of the younger child. But it also leads to a slight change in the nurse's role in the hospital, for the mother does much of the actual nursing of the child such as feeding and bathing, while the nurse mostly supervises and performs more technical tasks such as giving injections.

Many predominantly rural countries have developed a system of health centers, each with a team of medical, nursing, health education, and sanitation workers, combining their efforts to improve the health of the surrounding community. Knowledge of the material culture (such as housing, methods of disposal of excreta, water supplies, and available foods), the beliefs and values of the people, and their family structure is vital for the success of this teamwork as it is in all aspects of MCH work.

The provision of medical services sometimes has to be adapted drastically to the way of life of the community. For example, to reach the pastoral Masai in Kenya mobile health centers have been established which sometimes have to concentrate their activities around communal waterholes.

In no other aspect of child health is intimate knowledge of the local culture so absolutely vital for MCH workers as in nutrition; for the nutrition of a community depends not only on the production of foodstuffs, but also on the methods of food storage and food preparation and on the attitudes of the people to foods.

In some tropical regions, as in Buganda in east Africa, sufficient nutrients are available to prevent malnutrition, but despite this, protein-calorie malnu-

trition of early childhood is common because people do not make full use of the nutritious foods available.[12, 13] This failure to use what is available is often due to the idea that one type of food only is really food, and that other items are of no consequence. These cultural "superfoods" include steamed plantain (*matoke*) in Buganda, rice in much of southeast Asia, and maize in Central America. Also in some places certain types of food are prohibited to the whole community sometimes for elaborate cultural reasons, but sometimes merely because the particular item is not regarded as food.

Man everywhere, even under adverse conditions, eats only part of the actually edible material available. Even the nutritionally hard-pressed Hadza hunters of Tanganyika will not eat the blood of animals and meticulously discard the apex of the hearts of animals they have shot. Moreover, in almost every country there are prevalent concepts regarding the suitability of certain foods for certain people, especially children. Sometimes these ideas are nutritionally harmful, as in Malaya where fish, the main source of animal protein, is forbidden to children until they are 2 years old as it is believed that, if eaten by a younger child he will get worms.[14] Similarly, in parts of India the age-old *tridosha* (humoral) concept of body physiology means that a "hot" food, such as milk, must not be given to a person suffering from a "hot" illness such as diarrhea, even during recovery. This can have nutritionally ill consequences in a previously subnourished infant.

In many places the ideas that young children need specially prepared foods and three or four meals a day are practically unheard of; people do not make the Westerner's customary association between growth and food, between the qualities of different foods, and between malnutrition and a lack of certain foods. Thus kwashiorkor, although widespread in many tropical regions, is rarely equated with nutrition. Under these circumstances nutrition education is especially difficult, as the people are not motivated to make innovations in their food habits except in times of famine.

There is a widespread belief that eating well during pregnancy is undesirable since this might result in an overlarge fetus with consequent difficulty in labor. In Burma a customary maternal diet of small amounts of boiled polished rice means that the neonate has little stored thiamine. This contributes to infantile beriberi.[15]

However, in some tropical communities the pregnant woman is given a more nutritious diet than usual. Thus among the Basuto in South Africa, pregnant women eat porridge made of sorghum, which is more nutritious than the usual maize. When such a beneficial custom exists, it should be encouraged and incorporated into nutrition education.

This Berber mother in Morocco only recently learned that she could not cure her child's infected eyes with drops from the gall of a freshly killed vulture. Now she uses an antibiotic ointment supplied by UNICEF in its campaign against trachoma.

Because a people's use of foods is usually so bound up with their whole way of life, dietary custom is one of the most difficult areas of behavior in which to achieve any fundamental change. Small modifications based on indigenous practice are the most likely to be accepted. In Buganda mothers are being encouraged to use the traditional plantain leaf packets for preparing special high-protein meals for babies.[16]

For the majority of infants in tropical countries, breast milk is the *only* food given until the child develops one or two teeth. Thereafter, throughout infancy, breast feeding is continued, providing a small but significant protein supplement as the more digestible and nutritious portions of the available diet—protein foods both of animal and vegetable origin—are gradually added. However, among some tropical people such as the Bemba of Northern Rhodesia, breast milk is not regarded as food and other items are added early to the baby's diet, often leading to gastroenteritis.

This bottle-fed child in Trinidad is suffering from nutritional marasmus caused by infectious diarrhea and starvation.

Milk powder issued freely in child health clinics tends to encourage mothers to abandon breast feeding in favor of bottle feeding, unless the firm policy is adopted of mixing the powder directly with local foods.

The practice of direct distribution of the powder and the high-powered advertisement by milk-powder firms are potent factors in the falling off in breast feeding occurring at the present day in tropical regions. Among the unfortunate results is an increased incidence of gastroenteritis caused by pollution of the feeding through unsanitary methods of preparation and of nutritional marasmus caused by overdilution of the formula.[17]

The causative factors behind protein-calorie malnutrition—the major nutritional problem of underdeveloped areas—are rarely entirely nutritional. In Buganda, for example, the high incidence of kwashiorkor is undoubtedly correlated with the increasing tendency to stop breast feeding at even earlier ages and the reliance on a diet of steamed plantain. At the time of weaning, children are often sent away to relatives, especially a grandparent, and thus are subjected to emotional as well as nutritional deprivation.[18] One reason for this geographical separation at weaning is the belief that one form of kwashiorkor (*obwosi*) is due to the heat from a mother's pregnant uterus.

This practice of sending children away often delays treatment of the sick child as an older relative is more likely to hold the local concept of etiology and to rely on indigenous methods of treatment. Moreover, if modern therapy is not rapidly and obviously effective, the child is often removed from the hospital for herbal treatment at home. In Uganda a large proportion of milk powder is wasted because people are not prepared to persist with modern methods of treatment that take several weeks to produce a cure.

In planning health education, not only do the beliefs, attitudes, and behavior underlying the disease pattern have to be understood in order to formulate adequate educational objectives, but the structure of the society has to be understood also to enable the best use to be made of situations and personnel. Methods and media of communication have to fit in with what people know and can understand and accept.

In Buganda one of the major diseases of children is hookworm anemia, which lowers hemoglobin levels to a point necessitating emergency blood transfusions. Investigation carried out recently showed that while many adults used adequate pit latrines, children were sent to small, very shallow pits, or perhaps to just a defecating area in the plantain grove. The reasons usually given for this practice were that children if permitted to use the adults' latrine would soil it, or fall in, or would see their parents defecating; but another reason seemed to be a general feeling that the feces of younger and older generations should not mix.

Buganda parents of children with hookworm did not notice the pallor of their children's mucous membranes, nor did they attribute the disease to worms. The only intestinal helminths the parents did recognize were roundworms (thought to be due to the mother's unfaithfulness and, therefore, not usually reported), tapeworms, and pinworms. They were aware of a skin disease suffered after working in the fields, which was probably "the ground itch" due to the penetration of the skin by the hookworm larvae, but they tended to confuse the edema of severe hookworm anemia with the similar picture of kwashiorkor for which they had indigenous ideas of causation and treatment. Most peasant families could not afford to buy shoes for their children, who in any case probably gave the larvae plenty or opportunity to penetrate through the back, buttocks, and thighs.

When this information was gathered, pediatricians and other health workers were immediately struck by the unsuitability of their program of health education. They had been placing emphasis on the details of the offending organism's life cycle, using diagrams of the course of the larvae through the lungs and blood vessels—none of which could be understood by the local people. The health educa-

tion program was, therefore, redrafted to put emphasis on the transmission of the organism from feces on the ground to the human body through the skin, thus producing "ground itch" and the eventual result of loss of blood from the bowel. As visual aids, actual worms expelled from a patient were exhibited, together with before-and-after color photographs of the patient's mucous membranes. The chief emphasis was laid on ways of recognizing anemia and on the necessity of building latrines for children with the hole surrounded by an impervious material. All the old visual aids with dragon-size hookworms, anatomical line drawings, and emphasis on shoes and adult latrines were discarded.

With rapid culture changes and urbanization in most developing areas, new problems of health education have arisen, and will do so increasingly in the future. We have already noted one of the most serious, the abandonment of breast feeding. The difficulty in propagandizing against bottle feeding is that many members of the elite do not breast-feed their children. Efforts to persuade the poor to feed through the breast rather than bottles are apt to be interpreted as efforts to withhold something from the masses. Moreover, campaigns to encourage breast feeding are likely to make mothers self-conscious about it and so interfere with the complex psychological reflexes which seem to require that the whole process be taken for granted if it is to function naturally.

In Conclusion

Thus we see that a society's traditional food habits, child-rearing practices, and habits of personal hygiene along with other cultural factors shape the disease patterns of a community. The structure of the community, the functioning of the family and its attitudes toward innovation, the beliefs and attitudes of the people in regard to childbearing, disease causation, and food must all be taken into account in determining the work, the personnel, and the emphases of child health services. There must also be an awareness that the changes induced by the agents of modern scientific medicine are themselves not always beneficial, so that potential deleterious effects can be anticipated, and, if possible, prevented in advance rather than regretted later.

Cultural inexperience is expensive and wasteful. One million pounds of milk powder or a corps of experts may make no impression whatsoever on a problem, if the local culture pattern is ignored.

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Some day we shall be ashamed not to know how our neighbor lives, and when we truly know how he lives and why his children suffer, that kind of living and that kind of suffering will cease.

Julia C. Lathrop, first chief of the Children's Bureau, to the Illinois Conference of Charities and Corrections, Alton, October 22, 1916.

ORIENTATING PARENTS TO A CLINIC FOR THE RETARDED

ALICE V. ANDERSON

Social Worker, District of Columbia Clinic for Retarded Children, District of Columbia Department of Public Health

IN THE OPERATION of a clinic for retarded children, the following questions are repeatedly raised:

- How can the waiting list be cut down?
- How can the interest of parents be maintained pending the beginning of the study?
- How can parents be kept from breaking clinic appointments?
- How can parents be best informed about the work of the clinic?

Confronted with these provocative questions, the staff of our clinic set up a system of group orientation meetings in March 1960 for parents at intake as a method for improving the service of the clinic. The problems presented by the long waiting list and failure of parents to understand the clinic's services are now handled more effectively. Broken appointments in a multidisciplinary clinic involving the team approach especially had long been a matter of grave concern, since a broken appointment affects several staff members simultaneously, thus wasting the service of the clinic and allowing fewer children to be served.

The meetings, which are held in the evening, were organized and conducted by the chief social worker for parents of children on the waiting list. These are parents who so far have not been interviewed at the clinic. They have either telephoned the clinic to inquire about the possibilities of service for their child or have come to the clinic's attention through a telephone call from a doctor or another professional person. In either case the clinic has received little information about them other than identifying data. During the meeting, each parent is given a schedule of individual appointments with the social worker, clinical psychologist, physician, child development specialist, and speech and hearing specialist.

Since March 1960, the meetings have been held at regular intervals and are now attended by the pediatrician-director who acts as a medical resource consultant to the group. The parents are seen in groups averaging about 10 couples each. The individual appointments for each child and parent are spread over a 6-week period, the first parent coming to the clinic with her child a week after the meeting for the beginning of the study.

The group meetings provide the staff with a chance to find out which parents are still interested in the clinic service and to obtain from them signed forms permitting the staff to send for pertinent medical and social information in advance of their individual interviews. The meetings' most important advantages for the staff, however, lie in the opportunity they afford for observing the parents and gaining insight into each couples' attitudes toward their child, toward each other, and toward other parents with a problem similar to their own.

The rationale of this approach is to meet the parent's need for service at the time of the request. The parent who has contacted the clinic has already overcome one hurdle by beginning to accept the fact that his child may be retarded. Therefore, it is vital to provide service to him at a time when he is still searching for help for his child, before he has had much of an opportunity to become resigned to the child's problem.

Parents usually find some therapeutic relief in learning about the detailed diagnostic procedure the clinic has to offer and in being assured that their child will be seen and assessed by a team of specialists in work with children. The clinic's structure begins to have some meaning for them as they have an opportunity to see and inspect the different examining, testing, and play rooms where the study of the child will take place. Often they express relief at learning that the study is not to be conducted in a hospital atmosphere and that the children will not have to stay overnight.

Nervous tension is often aggravated in a family by the presence of a retarded child. In these discussion groups, tensions are often relieved when parents learn that mental retardation is not necessarily inherited. Some parents also find relief in learning that in comparison with others their child is not so badly handicapped. Parents are also often relieved to learn that their child can acquire self-help skills even though this can be accomplished only through a slow, tedious, training procedure, requiring repetition, relaxation, and routine.[1]

We hear much about parents who shop around from one clinic to another. This is not necessarily as unwise as many persons assume. Since there is considerable variation in medical practice, a parent may want confirmation of a diagnosis of mental retardation just as he might of any other medical diagnosis. Thus our clinic serves parents who may be known to other diagnostic clinics as well as those who are making their first clinic appointment. They are also widely different in educational and economic background, although families from the low-income groups predominate.

In order to help parents sense quickly what they have in common despite their wide differences in background, the group leader always points out that each has come to the meeting because of a deep concern about his handicapped child and that it is important for them not to blame themselves for the handicap. This does not mean that the parents are regarded as a homogeneous group or that they all feel the same way about their retarded child. However, at the time of the meeting they are all expressing their concern as parents of handicapped children. Recognizing this fact creates a sympathetic feeling toward one another and creates interaction among them. Mutuality of interest is more important to the members of such a group than are differences in their socio-economic, cultural, or educational background.

The social worker, through a permissive attitude, attempts to provide a "safe" climate for frank discussion among the parents. In the first part of the meeting she describes the clinic's services and what is expected of the parents. She also introduces some mental health concepts, pointing out that the clinic staff is as much concerned about the social adjustment of the child as with his physical condition. She also presents the concept of mental retardation as a symptom of biopsychosocial malfunction.

She encourages the parents to think of their child first and the handicap second, so that it becomes more than a difference in words when they say "my child who is retarded," rather than "my retarded child." Another point she stresses is that the mentally retarded child has the same desire to belong and be accepted by others as the nonretarded, and that in general his emotional needs for recognition, companionship, and a sense of usefulness are the same as those of the normal child.

Orientation Techniques

Many parents of retarded children deny the fact that their child is different from normal children before they finally accept reality. In these group meetings the social worker does not try to convince a parent that his child is below average for she realizes that while the discussion may be helpful in modifying the parent's attitudes, time will be the most important factor in this regard.

In describing the clinic, the social worker points out that it has been set up as part of the city's health program to provide complete diagnostic study and evaluation for any child under 18 who is a resident of the District of Columbia, and in whom there is a question of mental retardation. The parents are given a description of what goes into the diagnostic study and followup services, and of the work of the various staff members who participate: a pediatrician-director, two social workers, a psychologist, a child development worker, a nursing consultant, and a psychiatric consultant who have at their disposal various other consultants from the health department's staff including specialists in speech and hearing, neurology, electroencephalography, physical and occupational therapy, orthopedics, ophthalmology, and cardiology.

The social worker compares the clinic team approach to a family, telling how each member contributes his particular skill in order to help the other team members to do a better job as well as to help the retarded child. She also stresses the informality

and friendliness of the team members in order to help the anxious, hard-to-reach parents to become more relaxed so that they can become active participants in the study.

Focus on the Child

The second part of the meeting can be described as a group-intake interview through parent discussion. Social workers who have had responsibility over the years for individual intake interviews generally acquire considerable skill in quickly assessing the client's problem. This skill can be transferred to a certain extent to a group-intake setting. Of course, when a group is present the social worker cannot do as much interpretation of individual problems nor pick up immediately on some of the emotionally charged clues which emerge from the discussion. However, these clues often point the way to the focus of the subsequent individual interview.

What makes the intake interview so challenging, whether in an individual or a group setting, is that at this time, as the client presents his problems, the social worker is in a position to receive the full impact of his personality and his reactions to his problems. Later as the relationship continues and more detail complicates the picture, it is often more difficult for the worker to identify the trends which are significant for the assessment of the handicapped child in relation to his family.

As the parents describe their child's behavior, it often illustrates the child's social maladjustment. Problems in behavior such as short attention span, hyperactivity, temper tantrums, and a high degree of distractibility are described rather than examples of slow intellectual performance. It becomes evident that the children referred to our clinic are like the children at the Edenwald School of the Jewish Child Care Association of New York—"a group with retardation, emotional disturbance, and organicity all mixed up in a complicated dynamic pattern." [2]

When the parents are stimulated to think of mental retardation as a cause of their child's social dysfunction, impairing his ability to adapt, their overemphasis on the possibility of a physical basis to the child's difficulties tends to diminish. For example, the chief complaint of most parents is that their child is not talking, even though he may be several years old. Often parents assume that the child has some defect in his speech mechanism which treatment would alleviate. The social worker tries to help these parents understand that slowness of speech is often one of the characteristics of retardation and that a child usually understands more than he can communicate.

Although parents listen with interest and often ask questions in the part of the meeting devoted to an explanation of the clinic's services, their participation intensifies considerably when the focus shifts to their problems with their child. The social worker refers to this second half of the session as "their" part of the meeting for it is their opportunity to introduce themselves, to tell about their child, his age, his characteristics, and his relations with his siblings, and to state what they want and expect from the diagnostic study.

To get the discussion going, the leader invites the parents to volunteer to talk or to take turns in the order of their seating arrangement, as they wish.

At this point, the parents' interest turns quickly from the group leader to each other, as each parent describes the condition and individual characteristics of his child. The parents generally relate to each other quickly, gaining mutual support and sympathy. Rarely has a parent decided at the meeting that he does not want his child to go through the clinic study, although a few have decided afterward that they would wait a while before having the study made.

Mutual Support

The following example illustrates the way the parents find support in each other. A mother of a little Mongoloid baby had brought in a picture of her child for the clinic personnel to examine. This woman had a great need to deny that her child looked like a Mongoloid. As the discussion progressed, she passed the picture around to the other parents and a number of the parents reacted to it immediately. While some of the parents agreed with the mother that the baby did not look like a Mongoloid and others thought they saw some Mongoloid characteristics, the whole discussion seemed to develop a bond of sympathy and understanding in the group.

Often the group interaction has a more therapeutic effect than the explanations of the group discussion leader. This was true with Mrs. O, who described her 6-year-old daughter in somewhat critical terms by saying: "Mary knows what to do but she won't do it. She will repeat what I tell her to do but will go ahead with her play and ignore what I have said. Punishing doesn't seem to help. When she is asked why, she replies, 'I don't know'."

Obviously feeling irritated and frustrated at Mary's behavior, Mrs. O added, "I want this study

A group of parents who have applied for diagnostic and evaluation services for their children in an orientation session at the District of Columbia Clinic for Retarded Children.

to show me how I can make her do what I tell her to."

Very quickly a father spoke up, saying, "It's pretty hard to make anybody do anything for very long. Maybe it would be better to have someone tell you what might be the reason for Mary's acting up." Mrs. O nodded at this and the discussion continued.

Sometimes the social worker gets clues to be followed through later. A mother described her slow child as being the smartest one in the family about getting her own way. She said her child could run circles around anyone by coaxing, demanding, or making a fuss. Some other parents agreed that they had the same trouble. The social worker made a mental note that these parents needed help in modifying their children's manipulative behavior.

The parents' feelings of guilt do not come out in a group as often as might be anticipated. However, one very articulate, uninhibited father suddenly blurted out:

"Say, I have a sister in a mental hospital; do you suppose that's why my little girl is slow in developing? Would it be my fault since it's on my side of the family?"

Before there was time for the social worker to answer, another parent said: "It is like the lady said earlier: it's not to your credit if your child is bright and it's not your fault if your child is slow."

There have been times in the meetings when mothers have wept as they described their retarded child, but when this has occurred the group has accepted it calmly. One mother who was telling how difficult it is for a woman to handle a handicapped child alone said in a shaky voice: "My husband left me and now my little girl frequently runs away because she wants to find her daddy." The group was very silent as she struggled for self-control.

Another distraught and somewhat hostile mother of a retarded and emotionally disturbed 10-year-old boy said bluntly: "I want my child sterilized because I don't ever want to be responsible for rearing any of his children." The other parents looked stunned at first, and then began talking of their own fears of what the future would hold in the way of social relationships for their handicapped children. The social worker pointed out that many parents worried about this and that society does not provide a pat answer to the problem. She stressed the fact that each child is entitled to a thorough individual diagnostic study before any recommendation is made for his treatment.

Individual tape recordings of 12 of the parent group-orientation meetings have been made with permission of the parents. (They are available upon request to the clinic.) Demonstrating vividly the dynamic interaction which occurs as the parents discuss their children, they reflect both agreement and disagreement about suggestions made by the social worker as well as by the parents themselves, and show how the social worker uses opportunities to comment, interpret, or recommend a "let's wait and see attitude."

Patterns and Values

Over the months we have been able to detect certain patterns in these meetings.

We find that a group of from 8 to 10 couples usually promotes more interaction among the parents than a larger or smaller group.

We find that fathers often take the initiative in describing in detail their child's problems. And, contrary to our expectations, we have often found that fathers are readier to accept a diagnosis of retardation than some mothers. For example, fathers sometimes attend the meeting alone, their wives having stayed home as babysitters, and when this happens such statements as the following are not unusual: "I see this child as very different from other children in the family, but I wouldn't dare say this if my wife were here because she would hit the ceiling."

We find that parents want the support they get from other parents. Often at the end of the meet-

ing parents ask about the possibility of having further opportunities to talk together about their common problems. These parents usually become the nucleus of further parent discussion groups to which parents are invited after the diagnostic study has been completed, the evaluation conference held, and the interpretation given.

The feeling of mutual support engendered in self-led parent groups, such as those sponsored by local parents' organizations, is partly the reason why such groups have grown so in strength and numbers during the past 10 years. However, we have found that some additional advantages are provided when meetings are led by a professional staff person as part of the total diagnostic and treatment procedure of a clinic. This makes it possible for the meetings to—

- Be "treatment-oriented" instead of solely supportive and informative.
- Help parents consider their child's accomplishments and strengths as well as his limitations.
- Help parents, when necessary, to keep from revealing themselves too openly. (When a parent begins an emotional "confession" or starts bringing family skeletons out of the closet, the leader can intervene with a comment which universalizes what has been said or otherwise puts it into an impersonal framework.)
- Make it possible for every parent present to participate in the discussion. (The leader can, when necessary, tactfully terminate the discussion of a dominating member of the group and encourage a less articulate one to express himself.)
- Provide for intervention when the discussion gets blocked on an emotional level that only feeds the members' self-pity.
- Help parents become better informed of community resources which have programs for retarded children.

Although each meeting does not result in all of these advantages, some are always achieved.

The group orientation procedure also saves considerable staff time during the diagnostic study by reducing the parents' need to ask questions at this time. We find especially that parents who have met and talked with other parents who have similar problems do not so frequently ask, "Why did this happen to my child?"

The group-intake procedure also gives the staff opportunity to observe how husbands and wives react to one another, to other parents in the group, and to the social workers, thus gaining some indication of the quality of a couple's marital relations and of their other interpersonal and community relations. It also gives the staff an opportunity to learn about the parents' attitudes toward their child.

Since the clinic recommends but does not require both parents to be present for the diagnostic study appointments, the parent group-orientation meeting often provides the staff with the only opportunity to see the father. This is true even though a visit by the social worker to the home is regularly included as part of each child's diagnostic study.

By providing a means of seeing parents more quickly, the group-orientation procedure avoids anxiety-producing delays not only for the parents but also for the staff. We find that staff morale has improved now that appointments with parents and children can be scheduled well ahead, thus permitting orderly planning and acceleration of clinic work.

However, although the parent group meetings at intake have an educational and an orientation focus, their chief goal is to increase the parents' understanding of their child's problem. Unless the family is helped, factors contributing to the child's problem remain unchanged. When parents are helped through group discussion or individual casework treatment, or both, much can be done to relieve the effect of retardation and help the child to develop to his full potential.

As the parents listen to each other talk about their children, they often gain new ways of looking at their own problems, feel less isolated, and gain emotional support. Treatment actually begins at the parent group-orientation meetings.

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[2] Scher, Bernhard: Help to parents: an integral part of service to the retarded: repetition, relaxation, and routine. National Association for Retarded Children, New York. 1954.

[3] Scher, Bernhard: Help to parents: an integral part of service to the retarded child. *American Journal of Mental Deficiency*, July 1955.

People who are hungry and physically uncomfortable are difficult to reach with rehabilitative efforts.

Norman V. Lourie, deputy secretary, Pennsylvania Department of Public Welfare, to the 1961 conference of the American Public Welfare Association.

FOSTER CARE FOR DELINQUENT GIRLS

ELIZABETH V. HUNT
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JUDY, AGE 14, sat glumly before the judge of the juvenile court waiting for his decision. This was not the first time she had been in this chair. In fact, it was the fourth. Her offenses always were unauthorized absences from school or home, or both, once involving a ride in a stolen car, and once—this time—drinking. Each time the judge had placed Judy on probation and returned her to her family. This had not worked. What would he do now?

In working with Judy and her family, the probation officer had found that there were repeated difficulties between this young teenager and her parents, and strong feelings of rivalry between her and a younger sister. The parents had made only inconsistent and ineffective attempts to control her.

The judge again placed Judy on probation, but this time he did not return her to her parents. She was placed under the custody of the county welfare department for a year. Anticipating this order, the probation office had previously made a referral to the county worker who had talked with Judy and her parents. They were somewhat resistant but relieved that she was not going to the training school.

Six years ago Judy might have been sent to the small Ramsey County Home School for Girls, probably for a period of 6 months. The school had a combined function of detention and of ongoing care for girls who, it appeared, should not return to their own homes. The stay was short, often 3 to 6 months, but there many girls gained a different perspective.

Assisting the author in the development of the material for this article were Jane M. Grubb and Sara P. Hill, former caseworkers with the Ramsey County Welfare Department, and Beatrice Bernhagen, director of the department's welfare services to children.

In October 1957 when a detention home for girls and boys was opened, the girls' home school was closed. Its role of providing ongoing care for delinquent girls who could not be at home was superseded by a special foster family care program in the county welfare department. There, of course, continued to be a State training school for girls, known as the State Home School for Girls to provide the group care that some girls need. However, with improved community services, it was anticipated that most delinquent girls could be helped locally.

The specialized program for foster placement of delinquent girls began on January 1, 1958, with one social worker and a supervisor who also had other responsibilities. Because the caseload was expected to build up slowly, it was decided that the social worker who was to deal with the girls would also recruit and license foster homes for the program.

The scope of the program, as it has developed, includes work with the girls and their families, recruiting, licensing and sustaining the foster homes, and community interpretation. Experience has shown that for the worker to maintain a good quality of service in performing these functions, the caseload must be held to a maximum of 15 girls. Even this number allows less time than desirable for work with parents and still less for recruiting homes and making other community contacts. Because almost all of the girls in the program have been placed on probation for a year or longer as a result of a casework assessment of their behavior and needs, the number under care in the specialized program at any one time has become much larger than the former population at the girls' home school. A second worker was added to the program in August 1960.

The girls are referred to the Ramsey County Welfare Department by the probation office following a decision there to recommend to the court the girl's removal from her own home. Criteria for referral derive from consideration of whether the girl would formerly have been sent to the county girls' home school. Use of the county school had been based on a judgment that the girl needed a controlled setting but seemed able to use some freedom, such as going out into the community to attend school. The State training school is used for girls who are, like the others, beyond the control of their parents, who are unable to handle any degree of freedom, and whose associates and general behavior constitute a serious community problem.

The Girls

In the first 3½ years of the specialized foster care program, 66 of the 200 girls who appeared in juvenile court during the period were placed in foster homes. Of the rest, the majority remained in their own homes under supervision of the probation office, some were sent to the State school, and others were already in foster family care under the welfare department's regular boarding care program.

The length of stay in the specialized foster placement varied from 2 days to 25 months, the average being about 6½ months. Ten girls who could not adjust to the foster homes stayed only a few days or weeks. Of those who remained in their own homes, six later went to the State school, and one went to a treatment center and from there to the State school.

The girls who stayed longest in the foster care program were seriously disturbed but seemed to be making small gains under casework treatment. A few girls whose own homes had nothing to offer them have been committed to State guardianship and remain in foster family placement under supervision of another unit of the agency.

Early in the specialized program, most of the girls under its care were kept in placement until shortly before dismissal from probation, in an effort to give them opportunity to gain as much as possible from the experience of living with a normal, healthy family. However, subsequent experience has suggested that it is wiser to return the girls before the end of the probation period to the homes which contributed to their problems and to the schools and communities where they have a poor reputation, and to help them integrate the gains they have made.

Ages of the girls when they entered the program have ranged from 10 to 17, with a cluster around 14 and 15. There have been 59 Caucasian girls, including 2 Mexicans; 6 Indians; and 1 Negro. There have been 29 Catholic girls, 27 Lutheran, and 10 other Protestants. However, these religious affiliations were often tenuous.

The girls have had one to six appearances in court prior to referral and many also have had unofficial police records with no referral to court. Many come from families that have been known to social agencies for years. The average number of agencies which have had contact with the family is 6, the range being from 2 to 16.

The most frequent offense resulting in the girl's referral is "incorrigibility." Other common offenses are running away, sexual immorality, truancy, and drinking. There is some stealing as well as shoplifting, curfew violations, purse snatching, arson, malicious destruction, fighting, auto theft, and assault. The majority of the girls, even the very young ones, have had sexual experiences.

These are girls who act out their problems. They have in most instances shown a marked lack of respect for authority, including the court. They have been subjected to repeated admonitions and warnings from probation officers and court, sometimes without the consistence of follow-through in the establishment of controls. They react with surprise and even hostility when told that they are to be placed in foster care. Often at this point they are being held in the detention home, and their feeling of being punished carries over into their concept of the proposed foster home plan.

Psychological testing done at the detention home shows considerable variance among the girls. Some present the personality structure of many delinquents—impulsivity, immaturity, and rebelliousness—but others do not. From the standpoint of personality structure, these girls differ from one another to a marked degree, but they resemble one another in overt behavior, a common element being infractions of the law. The fact that the most frequent offenses among these girls are more harmful to themselves than to society has undoubtedly entered into the success of placements.

Once the referral has been received, the welfare department caseworker immediately talks with the girl and with her parents. These initial interviews are devoted largely to an interpretation of agency function and procedures, but necessarily include as well the offering of warmth and acceptance, the patient listening to hostility and defensiveness, and a consistent presentation of reality factors. The case-

worker estimates the suitability of foster placement for the girl and prepares a report for the court.

Because the agency has agreed to accept girls who would formerly have gone to the girl's home school on the determination of the probation office, the policy is to attempt to make a placement of every girl referred, insofar as possible, even though the prognosis for successful placement may seem poor, as occasionally it does. Even some girls who opposed placement and threatened to run away have been accepted and placed successfully. In a few instances, however, the agency has recommended against placement of girls who seemed so well established in delinquency as to need other kinds of help, or who refused to cooperate in any way. Some girls referred from the probation office have not been placed in foster care because of the judge's decision to return them to their own homes, keeping them under the supervision of the probation department.

The Foster Homes

Following the court's order for placement, the agency's task of selecting a foster home begins. This requires the caseworker to acquire more knowledge and understanding of the girl and her needs. The actual selection of the foster family for the girl is, however, only a small part of the placement process. The girl, her parents, and the foster parents are all drawn into active participation in an effort to achieve a mutual acceptance between the girl and her foster parents before the girl goes to her new home. The girl and her foster parents are introduced to each other before the placement, usually at the detention home. This tends to reassure the girl that her foster parents know the worst about her and still accept her. The process is complicated, however, by the fact that the detention facilities are often so crowded that there is pressure for the girl's early removal.

Early in the program the staff had some anxiety about whether adequate foster parents could be found to care for girls referred from the court. Many such foster parents have been found, however, through the insertion of ads in the daily paper requesting persons interested in boarding adolescent girls to call the agency. The ads make no mention of delinquency, but during the home studies the caseworkers talk about the special needs of girls who have been unable to live up to society's expectations of behavior. Applicants who have reservations about working with a child who acts out his aggressions are transferred to the agency's regular boarding home department. However, the majority of applicants who have indicated an interest in caring for an adolescent girl are willing, sometimes even enthusiastically so, to take one of these girls into their home. When there is not a licensed home within the specialized program to meet the particular needs of a girl, the help of the agency's home finders from its regular boarding home program is requested. As these workers have become more accustomed to the idea of placing a delinquent child, and have seen it work, they have become increasingly helpful.

Most of the foster parents in the specialized program have been young couples in their late twenties and early thirties with small children of their own. Older couples have occasionally participated, but it has been found that the girls tend to accept young couples more readily and that the younger foster parents are more likely to have a greater fund of patience, resiliency, flexibility, and determination to succeed. Moreover, having the satisfactions of their own families, the younger couples do not demand too much from the girls and are not afraid to risk failure. The girls on their part seem to enjoy children in the home, many having assisted their mothers with their own brothers and sisters. Moreover, helping with the care of the home and the children seems to have a therapeutic effect.

Most of the foster parents have only moderate incomes and modest homes. In some homes the girl can have a bedroom for herself, but in others the girl must share one with a younger child.

No foster parents have requested special board rates on the basis of the girl's record of delinquency alone. Usually they are paid at the same rate as in the agency's regular boarding home program. This is predicated on cost of care, but in the case of such problems as bed wetting, special rates are allowed.

Originally the staff hoped that as time went on a number of foster families would be able and willing to take a second child. However, while in a few instances a second girl has been placed with a foster family after the first has become firmly established, this has not happened to any appreciable extent.

The Girl at Placement

As she comes into the foster home, the girl is frequently attractive but tends to look older than her age. Usually she is physically mature and has a surface sophistication. Her hair is likely to be dyed, her hair style and makeup overdone, and her clothes too tight. Usually she smokes, and has an extensive vocabulary of socially unacceptable language.

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Some of the girls are openly hostile and defiant on first entering their foster homes, but most of them seem only frightened and wanting desperately to be liked and accepted. Most of them have probably suffered early physical and emotional deprivations; but whether this is so is not always known for, except for perusal of old agency records, the caseworkers make no effort to obtain full social histories. The histories of the girls' immediate pasts reveal, in many cases, openly rejecting parents; in others, parents who love their daughter but who because of personal inadequacies have been unable to meet her needs. In nearly every case, the girl has suffered from lack of care and training.

Typically, the girl entering placement has faulty relationships not only with her parents, but also with peers and with other adults. Her identifications, if any, are with other delinquents. Generally, she has a poor school record although she is of normal intelligence. Her life so far has been singularly lacking in achievements and satisfactions, and she has a very poor self-concept. She manipulates those about her because she cannot trust or accept them. She has a pattern of running from an unsatisfactory situation to something she wants and cannot identify. Operating on the pleasure principle because she feels that no one cares about her, she has little tolerance for frustration of her driving desires.

Within this general picture there are marked differences among the girls. The extent of personality damage may be minor or severe. Some girls respond quickly and easily to the help offered them, while others fight it. Some prove to have the ability and desire to achieve and earn recognition in a positive way. A few have character disorders. A few others are fighting so hard for the love of rejecting parents that they can never accept foster family placement. However, nearly all the girls on entering their foster homes are unhappy, anxious, fighting against society, and fighting for unfound satisfactions.

Before entering her new home, the girl has a physical examination and shortly thereafter a dental examination and whatever medical and dental care is necessary. The kind of dental care these girls had previously received is reflected in the fact that most of them have need for extensive dental treatment. Usually, too, their clothing is inadequate and new items are provided. The excitement of having new, attractive clothing, along with the abundance of attention from the caseworker and foster parents, helps the girl to get through the early days.

At the time of placement a clear understanding on the rules of probation is established by three-way discussion between the girl, the social worker, and the foster parents. These rules, which may or may not be written, are simple and few. They include instructions about hours the girl must be at home, her associates—excluding others on probation—school attendance, and, for the older girls, dating. At this time a specific plan for home visiting is also agreed upon. These visits usually are not made until the girl has had a sufficient period of time to allow her to work on her initial feelings about the placement and necessary controls.

In most instances the caseworker accompanies the girl to school and assists her with enrollment and such interviews as may be required with the principal or counselor. When the girl has been in the detention home, the fact that she has been in trouble cannot be concealed, and therefore the caseworker's support is needed both by the unhappy girl and the anxious school personnel. With the frequent histories of school difficulties, getting the girl off to a sound start in the new school is most important.

Foster Parents' Role

The part the foster parents assume in treatment is a demanding one and all-important in bringing about change in the girl's attitudes and behavior, for the foster home is the clinical setting in which growth and change are accomplished.

The foster parents are faced with precocious maturity and sophistication in some areas of the girls' development, and extremely immature, almost primitive behavior in others. They have to give basic training in personal habits such as cleanliness, grooming, care of clothing, and performance of simple household tasks. They also have to give training in the simplest social niceties, consideration for other people, use of acceptable language. To accomplish these tasks they must have an ability to tolerate much, to be patient and accepting, to look at the positives and overlook all but the most glaring negatives, and to be satisfied with small gains.

Foster father and mother teach the girls both by precept and example. For many girls, this is the first exposure to normal, healthy family life in a home where the members love and respect one another and where the parents act with authority that is consistent and unselfish. The foster parents are often the first persons to convey to the girls a feeling that someone thinks enough about them to care what they do.

These foster parents must listen sympathetically but objectively to the girl when she wants to talk, subtly helping her to face reality. They must recognize that she is striving for an affectional relationship with her own parents and that these parents may covertly or openly sabotage their own efforts to help the girl. They must be able to take criticisms from school and community without emotional reactions. They must also be able to accept the social worker's role in supervising the placement, and engage actively in teamwork with the social worker for the girl's benefit. When they do lose patience, or make mistakes, as the best of parents will, they must be able to admit it easily and go on from there.

The foster mothers carry a heavier load than the foster fathers since the mothers are with the girls longer hours and have the basic responsibility for their training. However, the mothers cannot function adequately without the support and help of interested and understanding husbands. Furthermore, because many of the girls have extremely poor concepts of men, the role of foster fathers in helping them to experience relationships with warm, mature, emotionally healthy men is extremely important.

Obviously, no couple can possess all of the ideal attributes for foster parents. However, the worker's understanding of each foster parent's strengths and weaknesses, gained in the study of the home, makes it possible for her to select the most appropriate couple for the girl being placed and to help them use their strengths to the fullest in meeting her needs. All foster parents need recognition, support, and direction in varying degrees.

The Social Worker's Role

The social worker must possess many of the same attributes as the foster parents—patience, warmth, acceptance, interest, firmness, and consistency. She must be able to accept hostility and use authority serenely. In the girl's eyes she is variously confidante, social worker, friend, mother, and truant officer as the girl's moods and needs change. She becomes an object of identification sometimes even to the point of a girl's dreaming of becoming a social worker. But she has an even greater responsibility. She must learn to know, to understand, and to help the girls in relation to their feelings about themselves, their peers, their natural and foster families, their school, and the community at large.

The social worker begins her work with each girl in environmental manipulation—planning for her physical care, placing her in the foster family and in school, arranging for clothing, for an allowance, and for the specific rules and regulations for everyday living. The worker's ongoing contacts with the girl continue to be reality oriented. Regular interviews have to do with day-to-day stresses, demands, and satisfactions. Within this framework, girls are frequently able to reveal much—their concepts of themselves, their families, and authority. They may make comments on a kind of living they have never before experienced and raise questions they have never had anyone they could ask.

The level of communication maintained by the worker is simple and direct, involving frequent repetition. The worker is strongly supportive and is careful to give praise when it is deserved as well as to point out areas where change is needed. The worker supplements the information given by the foster parents to help the girls achieve simple social know-how. Because the girls have little understanding of sex, though they may have had frequent sexual experiences, the worker attempts to help them understand and respect sexual functions. Since the girl needs to experience strong, consistent controls, and to feel that someone cares enough about her to take action when limits are overstepped, the worker returns to court to have the term of probation extended if she breaks the rules in any major way.

As time goes on, the interviews frequently acquire more depth, but the worker does not delve deeper than the conscious level. Psychiatric consultation is available to the worker, and occasionally a girl is referred to a psychiatric clinic for treatment. In preparation for the return home, the worker puts increasing emphasis on helping the girl to recognize and handle the stresses of everyday living, in an effort to integrate the gains made in foster placement. This emphasis on reality factors aids in tapering off the casework relationship.

With responsibility for working with the girl's own parents and the foster parents, the worker's pattern for giving service varies from case to case. In some instances she has many joint interviews with the girl and the foster parents. In others, when the girl may view such interviews as a threat, the worker sees the foster parents alone. The worker tries to see the foster father as well as the foster mother because his positive participation is so essential.

Goals for Parents

The worker's early contacts with the girl's own parents, again both father and mother, are usually focused on plans for placement, consideration of their

ability to contribute financially to their daughter's maintenance, and arrangements for visits to the girl. Subsequently, the worker keeps the parents informed of any changes in plan or of developments in which they may be of help. As planning moves toward the girl's return home, the worker steps up her activity with the parents and during the final months of foster care tries to help them understand how to set and maintain wise limits for their daughter's activities and how to exercise reasonable flexibility in supervising her. Through receiving simple, specific suggestions in ways of functioning as parents, many parents achieve change and find satisfaction in it.

As with the girls, the casework goals for parents must be limited but broad enough to assure the probability of parents and daughter being able to live together more comfortably and constructively than before. Where this does not seem possible, permanent separation becomes the goal and the focus of the casework with parents and daughter alike.

Some Values

This program has suggested that much can be gained by many delinquent girls from being placed in carefully selected foster family homes. The placement gives the girl an experience in normal family living which seems particularly significant in view of the fact that in a relatively short time she may be making a home of her own. It provides one-to-one, group, and community relationships, and a casework relationship of a kind that would probably not be available in an institutional setting. It provides the girl with opportunity for exercising individual responsibility under individualized limits for behavior.

Usually the girl's self-concept is enhanced during her stay in the foster home. She learns a pattern of living that can be transplanted directly into her own home and community, and when she returns home the same caseworker she had while in foster care is on hand to help her with the transplanting process.

Normal maturation, of course, gives a good assist to the success of this program for foster placement of delinquent girls. The younger girls usually do not gain as much as those in their midteens. The latter, for the most part, seem to be more accessible to help and able to change independently of their own families. They also show capacity to respond within a relatively short time.

The first step in helping the girls to change is to break their cycle of acting-out behavior, which they have not been able to do in their own homes. They seem to find it easier to accept limits in a setting where a healthy pattern of living is the established way of life. As their acting out decreases, they become more accessible to help. Through the combined efforts of foster parents and social worker, the pressures on them are relieved and their satisfactions increased. The girls then begin to participate more actively in bringing about change themselves. Not all succeed, and those who make progress do so in varying degrees. Even so, for Judy, and many like her, there may now be a homecoming filled with pride in a "new reputation," with an accompanying ability to maintain it.

In our concern for disorganized youth too many of us base corrective planning on an assumed close relationship between youth and the family circle, as if the major problems of youth necessarily fall within the scope of the family's wisdom and authority.

Actually, the needs that must be answered and the opportunities that must be created for a large proportion of youth—the half-grown—fall well outside the area of family influence. Their family conditioning has been completed for better or worse as early as the fourteenth year, in the case of many of them. What these half-grown youngsters now need is the exertion of a general community influence on the environment around them—an influence that will minimize the evil and maximize the better aspects of that environment.

Lester B. Granger, former Executive Director, National Urban League, to the 1960 White House Conference on Children and Youth.

THE DOCTOR AND THE HANDICAPPED CHILD

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THE PHYSICIAN plays a primary part in the development of the child who is handicapped. While he may never have a direct part in the occupational, physical, or speech therapy, or special education the child ultimately receives, he can set the stage for the successful use of these services by the way in which he helps the parents and child accept and work with the handicapping condition. This responsibility rests on the doctor because he is usually the first person to define for the parents the nature and extent of the child's handicap. This important event often occurs in the hospital at the time of birth, if the condition is immediately recognized, or later when the child is admitted to the hospital for observation.

What the doctor tells the patient or his parents about the handicapping condition is certainly important. *How* he tells them and how he and the hospital staff act toward the child or his parents can be critical.

We are constantly expanding our medical knowledge about the causes of various handicapping conditions, and for some conditions we have ameliorative surgical and medical therapy. However, for most handicaps we can only offer partial improvement in the actual physical condition, and for many we have no corrective therapy.

In the latter instances, the child, his parents, and the doctor ultimately have to face the fact that the handicap will be permanently present in some degree and will interfere with the child's normal developmental progress. Obviously this is extremely difficult for the parents and the child, but, perhaps not so obviously, it is also extremely difficult for the doctor. He has to admit that within his chosen profession he is failing because he cannot heal the patient. For this reason, some doctors find it difficult to give up various surgical and medical procedures that often consume a great deal of the patient's time, energy, emotions, and money, and lead to very little functional change in the handicap.

The physician who can accept the fact of his inability to remove the patient's handicap can help the child and his parents to accept it. Then everyone's time, energy, and emotions can be directed toward the best possible adaptation of the child to the everyday world. Some physicians handle this task exceedingly well and others make no effort to cope with it.

We know that doctors often fail to get the parents and their child started in the right direction when the handicap is first recognized. We know this from the reports of parents' complaints. For example, Dr. Koch and associates at the Los Angeles Children's Hospital in a study of the attitudes of parents of retarded children to the medical care received [1] found that parents were critical of what they were told, such as "put the baby away and forget about him," or "there is no hope;" and of what they were *not* told. "My questions about the baby's development were ignored" was a frequent complaint. Dr. Koch found that parents were also critical of *how* they were told about the baby's condition: for example, "The diagnosis was fired at us," "He told us in a cold way," "He was blunt," and "He tried to help, but wasn't informed," or "He wasn't interested in the child."

Such statements indicate not that the doctors

involved were cold, but that they were very emotionally involved because they felt helpless.

These feelings on the part of the doctor have been illustrated by Wilma Gurney [2] in a report written in 1961 of the Child Amputee Prosthetics Project of the University of California at Los Angeles, for which she was then chief social worker.

An obstetrician who delivered one of the babies now in the Child Amputee Prosthetics Project contributed to our understanding. He described his feelings as being very strong and personal, feelings of revulsion and of somehow not wanting to be around the mother. He found himself not wanting to see her or talk with anyone about it.

"After all," he said, "obstetricians don't like this sort of thing. Why do you think we chose this specialty? We don't like stillbirths or abortions, and especially we don't like anomalies."

He went on to compare serious anomalies with other devastating chronic long-term illnesses, saying they were much harder to face than cancer. He explained his thoughts this way:

"Death is really not so terrible. It's the living death that some people have to endure every hour of every day for years that is so devastating. This couple will have to watch their little girl grow up deformed and will be reminded all the time of the heartbreaking difference between her and other little girls."

It is apparent that the feelings about anomalies are strong in doctors as well as parents and can paralyze effective action. Nevertheless, how the doctor talks to the parents and how he conducts himself affects the child's future. Nonverbal is as important as verbal communication.

When Communication Fails

We physicians know that we have failed with parents and their handicapped children when we find that they are not able to accept or use the help of various specialists or special equipment that would be to their advantage. Such children and their parents are still trying to solve the initial crisis of accepting the fact that a permanent handicap exists, of recognizing that hiding from it or having magic dreams will not send it away.

Miss Gurney in another report of the Child Amputee Prosthetics Project at UCLA [3] found that the parents could be divided into three groups:

1. Parents who have sufficiently coped with the traumatic experience of having given birth to a child with an anomaly to be able to discuss the disability realistically; who realize and accept the child's need for both independence and dependence; and who have so freed themselves from self-blame that they can communicate understanding to the child and be helpful to him with his own problems of being different from other children.

2. Parents who are bewildered by the problems that are created by a child who is different; who continue to be troubled by a feeling of having caused the anomaly; who express concern about the reactions of strangers, friends, and relatives to the amputation and to a prosthesis; but who have the strength to look at their reactions and concerns and to make use of help.

3. Parents who have attempted to absorb the child in their own needs and conflicts; or who have isolated the child through avoidance of communication or insistence upon complete self-sufficiency; or who have withdrawn from close association with the family by illnesses or flights into activity; and who in defense deny the need for help.

The children in the first group of families are usually ready to accept a prosthesis immediately and will proceed promptly to learn how to use it. The children of the second group may not yet be ready for acceptance of a prosthesis. Often it is deemed advisable to defer prescribing one for such a child until he has a better understanding of his handicap, but everyone is optimistic that the child and his parents are accessible to help. On the other hand, the children of the third group almost never accept a prosthesis or try to use one correctly. Furthermore, the parents and children tend to reject help with their emotional problems. They are so hard to help at this point that the wisest course is to take steps to prevent this point from being reached.

Dr. Call, a UCLA child psychiatrist, in his report of group meetings with parents of cerebral palsied children,[4] found much the same types of parents' responses to children's handicaps as Miss Gurney. He emphasized the close emotional tie that some mothers developed with their handicapped children, a symbiosis that precluded the child's independent action and self-identification.

We have noticed in working with blind children that when some of them reach the age of 18 months or 2 years, they are still very infantile in behavior, having lacked stimulus from their parents toward any development of independence. Apparently frustrated by their inability to cope with the environment, they have begun to withdraw within themselves. By 4 to 6 years of age, some blind children appear severely retarded and are placed in State institutions where their downhill progress continues. Other blind children have received help early enough to bring them out of this early autism and have gone on to successful school careers. However, many parents of blind children could be helped to avoid letting the children get into such a state. The child has to be accessible to be able to benefit from educational programs for the blind.

What can the doctor do to help prevent some of these problems? He must, of course, define for the parents as clearly as he can the nature of the handicapping condition. Sometimes this is easily done, but sometimes, especially in regard to mental retar-

dation and cerebral palsy, the doctor cannot clearly see the prognosis. He must in any case try to explain, from a medical point of view, why the condition occurred. Sometimes he can do this; most often he cannot. He can, however, listen attentively to the parents' question, "What did we do wrong to cause this?"

And as parents describe some of the ways they feel they might have brought about the condition, the doctor can help them see that these were unlikely causal factors.

Next the doctor must provide the parents with some ways of dealing with the problem over an extended period of time. He must give them ideas and information that will permit several courses of action. The family needs to come to decisions of their own, in due time and in the quiet of their own home. Any abrupt suggestion to "put the child in an institution and forget about him" is ill advised.

Whatever information and help a doctor tries to give the parents should be given unhurriedly. They can only assimilate a small amount at a time. There should be opportunity for daily discussions between the doctor and the parents while the child is in the hospital. The parents and child (if an older child) should feel that they are not alone with their problem and that the doctor is ready to give them encouragement and moral support.

The type of handicap a child has is important in determining not only the management of the child but also the attitude of the parents toward the problem.[1,2,4-7] The age at which the handicap is clearly defined is also important in these respects and carries with it certain similarities for all types of handicaps.

Handicaps Noted at Birth

Physical handicaps noted at birth are for the most part obvious deformities such as congenital amputation of the arms or legs, deformities of the spine (spina bifida), and deformities of the face, including cleft palate and cleft lip, and the more general and sometimes more subtle physical signs of Mongolism.

The parents of the child with an obvious physical defect know immediately that the child will be handicapped in some measure and in the case of congenital amputation are aware that surgical and medical reconstruction will be of partial help only. Such a handicap has a rather sudden finality about it, bringing a crisis for the parents which is immediate and severe. The mother is usually informed of the anomaly before she sees the child, as she should be. But this means she often becomes filled with feelings of self-pity and guilt before she has held her child in her arms and learned to know him as a person. The mother of a child with a cleft palate and cleft lip may have similar feelings, but she usually knows that the condition can be ameliorated by surgery. The mother of the Mongoloid child is, of course, similarly shocked by the knowledge that her child is imperfect, but the deformity is less obvious to her. The probability of mental retardation is only a prediction that she can temporarily disbelieve until time forces her to face the facts.

The common factor in all of these situations is that the mother is told that she has a deformed child before she and the child have had any interpersonal interchange. This confounds the problem of establishing a strong, healthy, mother-child relationship. Miss Gurney has illustrated this:[2]

What happens to parents following the birth of an abnormal baby? Parents describe this period as living in a nightmare, with only the hope that it is a nightmare from which they will awaken. For those who are not permitted to see their baby, the nightmare is prolonged, making it difficult and even impossible to start dealing with reality. For those who are shown their baby in ways that reveal revulsion on the part of the staff at the sight of incompleteness or deformity, there is an imprint of rejection by persons who should have the greatest understanding of such conditions. For those who are left alone there is the sense of being outcast, of uncleanliness. For those who are fortunate, there is someone who recognizes their sorrow, who handles their baby with tenderness, who says by actions that though this is a disappointing and devastating thing that has happened, the parents are not going to be left to deal with it alone. Universally, parents feel they are alone with a problem that is hopeless.

Fortunately many mothers overcome this difficult emotional situation by virtue of their own emotional strength. Their children develop into successful participants in a prosthetics program, speech therapy class, or special education class. The important point is that many other mothers who might otherwise flounder in their mothering can be helped to establish a strong, healthy relationship with their babies.

It is the seemingly little things that are done in the hospital by the nurses and the doctors that can make the difference. The doctors and nurses who work in the newborn nursery enjoy that pleasant glow that is reflected by the happy mother with a healthy newborn baby. Everyone is upset when a deformed baby appears. The anxiety and depression that affects the staff is transmitted to the mother. This situation is hard to avoid, but there are constructive and destructive ways of handling it.

A common form of destructive behavior is the acting out by members of the hospital staff of their

own anxiety in efforts to "protect" the mother. The mother is not allowed to see the baby until she is "stronger," and no one talks to her about the child's deformity. The baby is placed in a special room and is often overtreated with the use of unnecessary incubators or special feeding techniques. Such behavior emphasizes the enormity of the problem for the mother.

Recently a baby with bilateral cleft lip and palate was born in the UCLA hospital. The inexperienced intern on duty in the nursery was justifiably upset and started to act out his anxiety by overprotecting the mother. We more experienced members of the staff urged him to get the mother and baby together as soon as possible and let the mother give the baby most of the feedings. He was hesitant at first, arguing that the baby weighed only 5 pounds and, therefore, needed special care in the premature nursery, and furthermore, because of the defect in his large palate, the baby would have to be fed by stomach tube.

We pointed out that since the baby was vigorous he would not need an incubator or other special premature care and that many similar babies nursed well from an ordinary nipple. We told him that many mothers consistently cut the rubber palate flap off of the special cleft palate nipples after they get home. The intern deferred to our greater experience, and the mother began giving her baby feedings on the first day, using regular bottles with ordinary nipples. We were all amazed at the ease with which this mother accepted the facially deformed baby and at the skill which she demonstrated in taking care of him.

In this instance we at least did not stand in the way of the development of a good mother-child relationship. We took one further step to try to avoid future problems. We know that this baby will be seen by many doctors and other professional persons in his childhood, such as the pediatrician, plastic surgeon, otologist, orthodontist, audiologist, and speech therapist, and that in a university clinic a patient can become lost in a maze of appointments and a confusing variety of advice. Therefore, we ask the social worker of the pediatric clinic to become acquainted with the mother in the hospital, and to become the mother's liaison with the rest of us. In private practice, the family doctor should play this role, and at UCLA we hope to train doctors to be able to do this well.

What we hope we conveyed to this mother is the idea that she can take care of her child better than anyone else. We also want her to feel that she is not alone and that we will always stand by to help her when she needs us.

Handicaps Noted Later

In such ways the doctor can help the parents of infants whose handicapping conditions are apparent at birth and in doing so help the child. But what about those children whose handicaps only become apparent sometime later during the first 18 months of life? Such conditions as blindness, deafness, mental retardation, cerebral palsy, and some types of handicapping congenital heart disease fall into this category. Because such conditions usually are unsuspected when the baby is in the newborn nursery, it is often possible for the mother and child to have a good and reasonably natural beginning together. But in these instances it dawns on the mother gradually that something is wrong. She then becomes disturbed in her management of the child because he is not following anticipated patterns of behavior. She blames herself for mismanaging the child or the child for misbehaving.

Often when the handicap is finally diagnosed and the mother learns from the doctor of her child's true condition, she is naturally resentful of the time she spent in unnecessarily tormenting herself or her child. She becomes angry with the doctor who did not discover the condition at the onset and with the doctor who did discover the condition but was too abrupt in telling the parents about it. It is a time of many recriminations.

The hospital staff, doctors, nurses, and social workers have to be prepared to accept the overflow of the parents' emotions, including anger, guilt, self-pity, and rejection. The parents need acceptance with all their troubles just as the child does. Too often we who deal with such parents are in a hurry to tell them that the child will do all right if they would only stop acting silly and use some rational common sense. This is desirable but takes time.

There is a natural tendency for such parents to act out their sorrow and feelings of guilt by doing everything for the child, and since the child at this age is still very dependent he has little chance to free himself. A concept to get across to these parents is that they should not prolong or exaggerate the child's dependence on them.

Children who become handicapped when they are older, through accident or illness, present an entirely different problem. They have had several years of normal relationships with their parents, siblings, and

friends. If all has gone well in these relationships, they have a firm emotional background to help them cope with the new crisis of being handicapped. Parents, friends, and doctors are often amazed at the skill with which such children can adapt to a handicapping condition. On the other hand, if the child is already emotionally disturbed and his relationship with his parents is distorted before he acquires the handicap, the new problem only adds fuel to the distorting forces.

In such instances, persons in a professional position must avoid focusing on the handicap in searching for a solution to the child's adjustment problem and must try to keep the child and parents from doing the same. These parents and their child need help with the problems they had before the handicapping condition developed.

The hospital staff can help the child by letting him know by their attitudes that he is just as acceptable with his handicap as he was before. They should accept his sorrow, depression, and anger with understanding, but without indulging in these emotions themselves. The doctor especially needs to represent an understanding and sympathetic pillar of strength that can withstand all emotional onslaughts. From this position, he can help the child and his parents deal with the handicapping condition constructively and keep it in its proper perspective.

In Summary

To recapitulate, no matter what handicap a child has or when it is first recognized, the physician is in a strategic position for preparing the child for later special therapy and education because he is the first to define the nature of the handicap for the parents and the child. The skill with which he deals with this critical moment is of paramount importance to the success of the future adjustment of the child.

In the newborn period, the primary goal must be the development of a healthy mother-infant relationship. The doctor must try to convey to the mother the idea that she can take care of her handicapped child better than anyone else.

In early infancy, the chief problem is the parents' tendency to act out their sorrow by exaggerating and prolonging the dependency of the child. The physician must help the parents see the need for letting the child grow toward independence.

In later childhood, the principal difficulty is to avoid attributing to the handicap problems that existed a long time before the handicapping condition was acquired. The doctor can help the child to understand that he is as acceptable in his handicapped condition as he was before, and to sort out those problems related to his handicap and those related to other factors.

In transmitting healthy concepts to the child and his parents, the physician must be helped by the attitudes and behavior of the entire hospital or clinic staff.

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The growth and development of a child does not wait upon convenience but is determined by the conditions in which his life unfolds. Ours is the twofold task of assuring a future fit for our children and rearing children fit for a future which shall be built upon foundations of justice, security and mercy for all.

Katharine F. Lenroot, former chief of the Children's Bureau, to the Eighth Pan American Child Congress, Washington, D.C., May 2–9, 1942.

An essay-review . . .

THE PROBLEM OF SCHOOL DROPOUTS

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THE Scholarship and Guidance Association of Chicago celebrated its 50th birthday in 1961. Those 50 years spanned an era of growing knowledge concerning the psychology of adolescence and the needs of the adolescent. When first organized, one of the major functions of the association, as its name implies, was to provide financial aid to students who otherwise would have been forced to leave school. However, this type of aid from the agency became less important as the availability of public assistance relieved the pressure upon young people to leave school to contribute to the basic needs of their families. While at no time in the history of the agency were the nonfinancial needs of adolescents ignored, the decreased need for its financial assistance and the growth of knowledge concerning the psychology of adolescence led the agency increasingly to use that knowledge to help young people whose emotional problems were interfering with the full use of their capacities.

It is appropriate, therefore, that in evaluating its work after 50 years of development, the agency has undertaken a study of school dropouts in the framework of prevention. The report of the study made by social workers Solomon Lichter (director of the agency) and Elsie Rapien, psychologist Frances Seibert, and psychoanalyst Morris Sklansky has recently been published under the title of "The Drop-outs."*

The cases reported in this book were selected by school personnel on the basis of behavior that suggested that the adolescents involved were potential "dropouts." Because of the criteria used for recognizing this behavior, the book focuses on individuals who might be expected to discontinue school for psychological reasons. These cases provide clues both to certain psychological constellations that may lead a young person to drop out of school as soon as the law permits, and to extremely interesting illustrations of constructive approaches to certain types of potential dropouts.

The psychological constellations observed in this group of cases are similar to those that might be observed in any cross section of emotionally disturbed persons of any age. But among adolescents there appears to be higher frequency than in other age groups of the utilization of escape when a conflict arises which is rooted in any of these constellations. Too many adolescents, for example, who are hostile toward authority, rebellious against it, or feel trapped by it attempt to deal with these feelings by escaping from the authority of the school, only thereby to expose themselves to the authority of job foremen. They are unable to strive for the long-time goal of equipping themselves for work in which they would be required to bow in authority. Likewise, in instances in which there is a need to be defiant, the adolescent too often chooses the escape pattern of leaving school rather than a pattern which would not make it necessary for him to lose the benefits from schooling.

The escape aspect of the adolescent's response accents the importance of instituting therapy with the disturbed adolescent before he reaches the age at which he can legally choose actual escape from school in his efforts to handle this conflict. Thus, the urgency of helping adolescents to resolve such conflicts derives not solely from the nature of the conflict; in fact, the resolution of adolescence in

*Lichter, Solomon; Rapien, Elsie; Seibert, Frances; Sklansky, Morris: The drop-outs. The Free Press of Glencoe, New York. 1962. 302 pp. $5.50.

many cases might itself erase the conflict's most crippling aspects. However, if an adolescent attempts to resolve the conflict by discontinuing his education, this solution may have a more seriously crippling effect on his future than would an inadequate resolution of the conflict.

The effectiveness of therapy while the young person is required by law to be physically present at school is impressively described in "The Drop-outs." The book documents the belief that the disturbed adolescent can be helped to understand his problems, to find a more constructive solution to them, and to alleviate some of the modifiable situations which have created the difficulty. I suspect, however, that understanding the conflict, a redirection of its solution, and alleviation of its reality components may not have been the main forces which modified the behavior of the adolescents the book describes.

Often when his action is the result of some emotional conflict, an adolescent consciously knows the nature of that conflict. His insight in regard to the conflict only supports the act that expresses it. In such cases this negative use of insight can be modified only when the adolescent is able to accept a meaningful relationship with an adult who understands the nature of the psychological difficulty. Although the positive nature of the client-therapist relationship is discernible in the therapy reported in "The Drop-outs," it is perhaps not sufficiently stressed. Possibly the insight the therapist had into the emotional difficulty of the adolescent was at least as significant as the adolescent's own insight.

Some Omissions

Because of the criterion used for the selection of cases to be studied, there were two types of cases omitted in this report: potential dropouts who are limited in intellectual ability; and the "covert dropouts."

The adolescent who has a below-average learning rate requires us to look at this question: What is the validity of a compulsory educational law which requires a young person to remain in school even though the only further learning he can be expected to acquire is how to sit quietly, listen, and make a pretext of grasping subjects that are beyond his ability to comprehend? Such a learning experience may lead to a psychological handicap in adult life as serious as the loss of education is to the individual who can profit by education.

The authors by omitting the intellectually marginal group of adolescents were able to avoid the question of how a community can enable such young people to make an optimum contribution to society and to gain more self-gratification. Until areas of possible educational expansion to benefit such young people are identified and suitable programs provided, "the stay-in-school" of this group may be as seriously handicapped, though less obviously so, when he becomes an adult as the "dropout" who has superior learning ability.

The "covert dropouts," another group of young people who should be considered under the broad category of "dropouts," are referred to only indirectly in this report. They are individuals who remain in school and learn their lessons, but though they learn the tools for future work or the subjects that will enable them to gain tools for their future work from college attendance, they are not educated. The many reasons for this failure to become "educated" are closely related to those which cause other bright youngsters to drop out of school. In addition, there is probably another rather obvious factor involved—the goals of education as presented to the young person by adults. If keeping a child in school as long as he can profit from formal education is valid, should we not consider the effect on young people of our most frequent argument for school attendance?

Young people are told that the more schooling they have, the better, and especially the more financially remunerative, the job will be that is available to them. Thus the diploma and not what the diploma represents becomes the aim of the student as he remains in school, and the high-paid position his goal on graduation. While it is important to encourage every young person to acquire tools for his future work and thus for establishing his vocational and social identity, such a goal only provides a passport into adult life. It does not make him an adult.

The current criticism of today's college graduates as materialistic and self-focused in their selection of careers and positions seems to fit a large number of young people. This calls for recognition of the fact that in addition to the numbers of overt dropouts from high school, about whom figures are frequently released, there are a great many covert dropouts. The latter, at least, are available to educate since they remain in school. But the problem of relating education to greater depth and breadth of living is not touched upon in the book, "The Drop-outs."

The book does bring out the necessity of the therapist cooperating with the school and the school cooperating with the therapist in working with

potential dropouts. The authors found the schools very willing to tolerate disturbed behavior, to modify their approach to the student who was under treatment, and to wait for results as long as they were aware of the fact that therapy was being undertaken and were kept abreast of developments.

Too often the therapist who is interested in working with an individual in isolation from the rest of his life unconsciously shares the adolescent's resistance to parents and school authority. Under the dignified robe of therapist he, himself, is a "drop-out." In some cases at least, the therapist's isolation from the school probably either enables him to ignore the vicarious gratification he gains through his client's or patient's resistance to school or enables him to utilize his understanding of the young person to consolidate his own hostile, rejecting attitudes toward adults. In such instances, the adolescent and therapist share a negative point of view, even though the therapy may seem to be successful because the young person stays in school. In the cases presented in "The Drop-outs," this type of isolated therapy has been avoided.

However, the authors of "The Drop-outs" labored too hard to identify the problems their young people presented according to psychoanalytic phase differentiation. When the cases are described and discussed rather than labeled, they become alive; they lose some of their aliveness as they are redefined in what apears as rather stultifying use of psychoanalytic terminology. Fortunately the real value of the study is not masked by such terms.

The study offers an opportunity to examine certain important facets of the question as to why students of average and above-average intelligence with no financial need to begin working leave school as soon as they legally can, in spite of pressure from home and school not to do so. It stresses the emotional problems that the young person anticipates he will solve by leaving school. Thus, it is a study of a symptom—discontinuing school—which like so many symptoms may have any number of causes. The emotional problems which produce this symptom may in other adolescents produce other symptoms, for it is characteristic of emotional problems that their symptoms vary. Therefore, the elucidation of the emotional difficulties of adolescents as presented in this book provides an understanding of adolescents in general and not just the adolescent who will leave school.

GUIDES AND REPORTS

SEPARATION ANXIETY: A CRITICAL VIEW OF THE LITERATURE. John Bowlby, M.D. Child Welfare League of America, 44 East 23d Street, New York 10. 1962. 20 pp. 60 cents.

A reprint of an article that appeared in the February 1961 issue of the *Journal of Child Psychology and Psychiatry.*

SOCIAL WORK PRACTICE IN THE HEALTH FIELD. Harriett M. Bartlett. National Association of Social Workers, 95 Madison Avenue, New York 16. 1961. 285 pp. $3.50.

An analysis of social work practice in general and in health agencies, with a comparison of methods used by this discipline and others in the health field.

THE YOUTH QUESTION: IS IT A PROBLEM AND FOR WHOM? R. Alex Sim; and A CRITICAL LOOK AT YOUTH SERVICES IN THE 1960's. Joseph Laycock. Selected Papers No. 4 from the 41st annual meeting and conference of the Canadian Welfare Council, May 29–31, 1961. Canadian Welfare Council, 55 Parkdale Avenue, Ottawa 3. 1961. 24 pp. 50 cents.

Two papers from the conference which had the overall theme: "Social Policy in the Sixties."

GUIDE TO THE CONTENT OF SECOND-YEAR FIELD TEACHING IN CASEWORK. The Committee on Content, School of Social Service Administration, University of Chicago. The University of Chicago Press, Chicago, Ill. 1961. 42 pp. 75 cents.

With the purpose of assuring a basic core of field-work instruction to all students, regardless of setting or individual instructor, this pamphlet was prepared by a committee consisting of field-work instructors and consultants from various settings, and presents the committee's findings on the generic content of what is taught in the school's course for second-year field work.

PEDIATRICS AS A CAREER. American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Ill. 1962. 18 pp. Free on request from the Academy.

Designed for premedical and medical students and interns, this illustrated pamphlet discusses pediatrics in relation to disease prevention, mental hygiene, juvenile delinquency, the growth and development of children, congenital malformations, prenatal events, care of the newborn, serial health examinations, and pediatric subspecialties.

BOOK NOTES

THE CULTURALLY DEPRIVED CHILD. Frank Riessman. Foreword by Goodwin Watson. Harper & Bros., New York. 1962. 140 pp. $3.95.

To exploit the vast reservoir of intellectual talent among culturally deprived children that lies "virtually untapped" in public schools tuned to middle-class norms, Dr. Riessman, chairman of the psychology department of Bard College, challenges school systems to take into account the culture of lower economic groups and the mental styles it produces among children.

He draws on a number of studies to show that deprived children from underprivileged groups are educable and tend to be physically and visually oriented; inductive rather than deductive in thinking; slow, careful, and persevering in important matters; and though handicapped in verbal expression, able to display an inventive wordpower of a kind unappreciated in school. Deficient in school "know-how," they tend to be slow learners who favor the three R's and science over art, music, and the social sciences, the author says.

One of the book's 12 chapters brings into relief some positive qualities in the culture of deprived groups—their stress on ruggedness and vigor, cooperation, family cohesion, and informality, and their warm humor—all of which the author says can be helpful in promoting learning.

The final chapter, "Ideas for Action," urges teachers and others working with deprived children to study their background, especially its positive elements, look for hidden IQ's, give more attention to slow learners, and develop their reading skills as well as their ability to take a test.

In a roundup of suggestions for teachers taken from his own and others' works, the author includes development of special education for teachers of deprived children, lengthening college programs to 5 or 6 years for slow learning students, teaching in traditional ways rather than through "progressive methods," and "masculinizing" the schools because the current stress on feminine values conflicts with these children's culture norms and inhibits their development.

Throughout the book the author stresses the point that adults must respect these children in order to help them to learn.

BEHAVIOR AND DEVELOPMENT FROM 5 TO 12. Glenn R. Hawkes and Damaris Pease. Harper & Bros., New York. 1962. 375 pp. $5.75.

The "middle years" of the child and his world are described by the authors, both of whom are affiliated with the Department of Child Development at Iowa State University. The concepts presented are based on research and observations from the biological, social, and behavioral sciences, and are illustrated by excerpts from case histories and pertinent literature, and by graphs, charts, and photographs.

The physical, emotional, social, and intellectual growth of the child are discussed along with material on family, school, peer group, community, and the impact on youngsters of the mass media of communication. The book closes with a chapter on techniques for observing and recording child behavior, a summary of behavioral characteristics of youngsters at different ages, and a "preview" of adolescence.

An extensive appendix contains an annotated bibliography of films and publications.

SCHOOL VOLUNTEERS. T. Margaret Jamer. Public Education Association, New York. 1961. 200 pp. $3.95. ($4.10 postpaid.)

In introducing this record of the experience of an organized volunteer program operating in some of New York City's public elementary schools—to help offset the effects of crowded classrooms and overworked teachers—the author, who is the program's director, points to the "waste of human potential" that comes from inadequate education in the early years. Such inadequacy, she maintains, is "seldom overcome in high school." The book depicts the way trained, supervised volunteers relieve teachers of routine and extracurricular chores to free them for fuller attention to teaching; rescue hundreds of children from an "educational no-man's land" by giving them individual help, sometimes in reading; and enrich the children's lives in art, crafts, music, languages, dramatics, journalism, and creative writing.

After outlining the organization of the program by the Public Education Association (inspired in part by a 50-year-old London experiment), the author turns to the program's development, reviews recruiting and operating procedures, describes the variety of volunteer tasks, and appraises the program. She also gives advice on staff-volunteer relations and coordination, and optimum numbers of volunteers (30 to 50 with a volunteer chairman per school). A generous number of illustrations, including samples of forms and questionnaires for staff and volunteers, contribute toward the expressed purpose of this book: a guide for other communities and potential volunteers.

CREATIVITY AND INTELLIGENCE: explorations with gifted students. Jacob W. Getzels and Philip W. Jackson. John Wiley & Sons, New York. 1962. 293 pp. $6.50.

The distinction between creative and intelligent thinking has been lost in the rush to apply the intelligence test as a metric by which "individuals are evaluated and sorted, given preferment or denied it," according to the authors of this book, two educational psychologists, both with the University of Chicago. The book reports on their explorations, during 1957–59, of creativity and its relation to intelligence. These were made by comparing two groups of pupils (totaling 449) in the junior and high school grades of a Chicago private school. One group, high in creativity, did not test high in intelligence, and the other, with high intelligence scores, did not make high scores on creativity tests.

Three of the book's five chapters present profiles of the two groups, inter-

laced with theories regarding giftedness. They show, for example, that the young people in the creative group, though achieving as well scholastically (but not in popularity with teachers) as those in the other group, had more humor and openness in self-expression—more self-confident and tolerant parents and less specialized family occupations—and less achievement-motivation and precision.

Another chapter reports on a similar study of the sample in relation to "morality"—defined as involving seven specific traits including identification with humanity and holding to personal ideals regardless of social pressures—and social adjustment or psychosocial functioning, judged by such traits as relative freedom from morbid fantasy, defeatism, and hostility. Of two groups, one scoring high in "moral" qualities but low in adjustment, and the other showing the reverse scoring pattern, the "moral" group revealed, among other things, greater concern with "becoming," and the socially adjusted, greater concern with "being."

In the final chapter reports on clinical studies of several pupils are followed by descriptions of the study's instruments and procedures.

The authors suggest that ways be sought for society to reward rather than penalize independent thinking and other expressions of creative valor.

ESSENTIALS OF PEDIATRIC PSYCHIATRY. Ruben Meyer, M.D., Morton Levitt, Ph. D., Mordecai L. Falick, M.D., and Ben O. Rubenstein, Ph. D. Appleton-Century-Crofts Division, Meredith Publishing Co., New York. 1962. 208 pp. $6.

For the pediatrician, whose work, according to the authors, has become concerned less and less with therapy and more and more with prevention and questions of child rearing, learning problems, phobias, and other emotional disturbances, this volume outlines some basic knowledge about the normal psychic development of infants and children and their emotional problems—to serve as a model on which he can "flesh in" from his own experience.

Drawing attention to the ways in which psychiatry and pediatrics have cross-illuminated each other and the high degree of compatibility between the two disciplines, the team of authors, who are faculty members of the Wayne State University College of Medicine in Detroit, present first the broad lines of psychic development, according to psychoanalytic theory. Then they proceed to describe, in addition to the manifestations of normal development, children's emotional reactions to trauma and hospitalization, serious disorders of development, ways of evaluating borderline and pathological cases, and when and where to refer patients.

According to the authors, the material is "neither eclectic nor extensive," but rather selective of areas that are of major concern to pediatricians.

DIALOGUES WITH MOTHERS. Bruno Bettelheim. Free Press of Glencoe, New York. 1962. 216 pp. $3.50.

Dr. Bettelheim, director of Chicago's Orthogenic School, presents here a series of selected tape recordings of parent education meetings he conducted over a period of several years with a group of young, normal mothers whose husbands were students at the University of Chicago, and who brought him the kind of child-rearing concerns common to mothers in a middle-class, upwardly mobile group.

Rather than advising the group participants, Dr. Bettelheim attempted through discussion to bring out the observations, knowledge, and insights of the mothers themselves. This book is intended primarily for parents whose background is similar to those who took part in these discussions.

BASIC ANXIETY: a new psychobiological concept. Walter J. Garre. Philosophical Library, New York 16. 1962. 123 pp. $5.

The genesis of diffuse anxiety in humans, according to this author, goes back to a "basic anxiety" which he says is felt by all infants in varying degrees depending on the degree of rejection, or seeming rejection, of the infant by the mother or mother substitute—an anxiety rooted in a fear of destruction, abandonment, or of being unprotected in the face of danger. The author, who is Chief of Psychiatry of the Veterans' Administration in San Francisco, attributes most human dysfunctioning in what he calls the physical, "social-mental," reproductive, and economic spheres to overreacting on the individual's part. For example, he maintains that overstimulation of the peptic juices is a result of early fear of abandonment and thus of starvation, and that chronic fatigue comes from excessive outpourings of energy in reacting to the continued presence of "basic anxiety" throughout life.

Because this loss of energy draws off ego strength, the author suggests that the more emotional investment the child originally receives from his parents, the more ego strength he will attain as an adult and will be able to pass on to his own children. The emotional capacity of a family remains constant from generation to generation, he concludes, adding the suggestion that the familial occurrence of deficiencies is not due to defective germ plasma, but to "unconsciously conditioned selective mating."

ACCIDENT PREVENTION: the role of physicians and public health workers. Prepared under the direction of the Program Area Committee on Accident Prevention for the American Public Health Association, with the cooperation of the Public Health Service, Department of Health, Education and Welfare. Maxwell N. Halsey, editorial consultant. The Blakiston Division, McGraw-Hill Book Co., Inc., New York. 1961. 400 pp. $12.

This book, directed primarily to physicians and public health workers, presents a comprehensive view of the total field of accident prevention.

Chapters are devoted to the magnitude and epidemiology of the overall problem, and to the problems of special age groups—children and the aged. Other chapters are concerned with safety in specific settings—the home, farm, school, traffic, industry, recreation, and even industrial fleet driving and private flight. Safety activities are also discussed from the point of view of the physician's role, programs for medical societies, and programs for public health agencies. Chapters on emergency care, professional education, factfinding, and research complete the presentation.

Under the general direction of the American Public Health Association Committee on Accident Prevention, each of these chapters has been contributed by a leader in the safety field.

HERE AND THERE

Public Welfare Amendments

On July 25, President Kennedy approved the Public Welfare Amendments of 1962 which he described as "the most far-reaching revision of our public welfare program since it was enacted in 1935." The new law, Public Law 87-543, amends both the public assistance and the child welfare provisions of the Social Security Act.

The child welfare provisions (title V, part 3) are amended to provide for:

- Increases in the Federal funds that can be appropriated for grants to the States for child welfare services from $25 million to $30 million for fiscal 1963, $35 million for fiscal 1964, $40 million each for fiscal 1965 and 1966, $45 million each for fiscal 1967 and 1968, and $50 million per year thereafter.
- Clarification, and some broadening, of the purposes for which such grants may be used, through a definition of child welfare services.
- The earmarking of a portion of the funds appropriated under the increased authorization for the provision of day care services. The maximum amount so earmarked is not to exceed $5 million in fiscal 1963 or $10 million thereafter. The earmarked funds are to be allotted among the States on a formula basis, with a minimum allotment of $10,000 per State per year.
- Grants to institutions of higher learning for special projects for training personnel in the field of child welfare. These projects may include traineeships.

As conditions of plan approval, effective July 1, 1963, each State's child welfare services' plan must show—

- Coordination between the services provided under it and those provided for children under the State's plan relating to dependent children under Title IV of the Social Security Act.
- Provision for extending child welfare services throughout the State, so that by July 1, 1975, they are available to all children in need of them. State and local child welfare services' staff, to the extent feasible, are to be trained child welfare personnel, and, in extending service, are to give priority to communities with the greatest need.

If day care services are to be provided, the plan must include—

- Cooperative arrangements with the State health and education agencies, to assure maximum use of these agencies in the day care program; a State advisory committee on day care; safeguards to assure that day care is used only in the best interests of the child and the mother; provision for payment of reasonable fees by the family when appropriate; and arrangements for giving priority to members of low income or other groups having the greatest need for day care.

Needy Children

The amendments affecting public assistance include significant changes in the aid-to-dependent-children program (title IV), the name of which was changed to "aid and services to needy families with children."

One extends for 5 more years the Federal-State program of aid to children of unemployed parents which expired on June 30; and another makes permanent the temporary provision allowing Federal participation in the cost of foster family care of children who are recipients of assistance. To the latter has been added a provision for Federal participation for the next 2 years in payments for foster care in nonprofit, private child care institutions.

Other amendments to title IV allow Federal participation in—

- Payments which include provision for a second parent who is living in the home and is incapicitated or unemployed.
- Payments to recipients for work performed in community work and training projects of a constructive nature, if certain safeguards to protect the recipients and their children are met.

Among the required safeguards in this provision are: appropriate health and working conditions, including health and safety standards and protection under the State's workmen's compensation law; rates of pay which are no lower than the State's legal minimum and the prevailing community rates; opportunity for the worker to seek regular employment and to receive any available and appropriate training; allowance for expenses appropriate to work in determining the family's need. The States are also required to make maximum use of the job-placement facilities of the State employment service and of the retraining programs of the State vocational education and adult education programs; and to make sure that appropriate arrangements for the care of the worker's children have been made. Recovery by the State of payments made for work accomplished is prohibited, as is denial of aid to persons for refusal with good cause to perform work.

This provision has a 5-year limit before the end of which the Secretary of Health, Education, and Welfare is to prepare a report on the experience under it for Congress.

- "Protective payments" made to a person other than the caretaking relative in instances in which the State welfare department determines that the inability of the caretaker to manage funds is such that the well-being of the child is adversely affected.

The number of individuals for whom such payments may be made in a month is limited to 5 percent of the number of other recipients under the program, and again a number of safeguards are required, including provisions for: continuous effort to develop the caretaker's ability to manage; periodic review of the situation and the appointment of a legal guardian if after a specified period of time the caretaker is still unable to do this; an opportunity for the caretaker to have a fair hearing.

To be eligible for Federal participation in protective payments, the States must have foster home care provisions in their plans for aid and services to needy families with children.

Another amendment to the act provides for the appointment of an advisory council by the Secretary of Health, Education, and Welfare in 1964 to review the administration of the public assistance and child welfare programs and to report its findings and recommendations by July 1, 1966. The council is to be composed of 12 persons

representative of employers, employees, State or Federal agencies which administer or finance public welfare programs, private welfare organizations, the public, and persons with special knowledge or experience.

Other amendments to the act authorize Federal funds to encourage States to provide rehabilitation services for public assistance recipients; and provide for the use of Federal funds for the direct training of workers capable of giving such services as well as for stipends and scholarships.

CB Appropriations

As finally passed by both Houses of Congress in late July, the Children's Bureau appropriation for fiscal 1963 included $2,853,000 for salaries and expenses—an increase of almost $200,000 over the amount for 1962. It also included $75,795,000 for grants to the States under Title V of the Social Security Act. This includes $25 million for each of the three programs of grants to the States under this title—maternal and child health services, services to crippled children, and child welfare services—and $795,000 for grants for research or demonstration projects in the field of child welfare.

The appropriation for child welfare services represents an increase of $6,250,000 over last year's amount, and the appropriation for research or demonstration projects in this field, an increase of $520,000.

Refugee Assistance

In late June, Congress passed the Migration and Refugees Assistance Act of 1962, placing in a single vehicle the previously diffuse Federal authority to assist political refugees from other lands. The act authorizes appropriations for assistance and services to refugees who "have fled from any area in the Western Hemisphere and cannot return thereto because of fear of persecution on account of race, religion, or political opinion." Funds for such aid, as in the Cuban refugee program, have up until now been drawn from the President's contingency fund. (See CHILDREN, May–June 1961, p. 116.)

The act's definition of "refugee" now makes it possible to extend aid under the Cuban refugee program to persons who had fled to Cuba as political refugees and who have recently come to this country for asylum. Such persons did not qualify for aid under the directive which originally established the Cuban refugee program, as this was limited to Cuban nationals.

The act also carries provisions for contributions of the United States to activities of United Nations High Commissioner for Refugees.

International Planning

The 1962 meeting of the Executive Board of UNICEF, held in June, marked the completion of the first year of new policies leading to an expanded program. (See "Future Directions of UNICEF," by Maurice Pate, CHILDREN, September–October 1961, p. 191.) Among the new types of projects approved for aid were six in the field of education—two in Africa, two in Asia, and two in the Eastern Mediterranean. Five are focused on training teachers for primary schools; the sixth (in the Congo, Léopoldville) is aimed at an immediate increase in enrollment in secondary schools with concurrent efforts directed to teacher training. In each case, the curriculum will be reoriented toward the real-life prospects of the child. In primary education programs in Iraq, Thailand, and the Congo, stress will be placed on teaching practical skills, particularly for the improvement of nutrition and health education.

UNESCO will be closely associated with UNICEF in the implementation of these projects, as it was in their planning. Attending the meeting was the chief of UNESCO's Department of Education who expressed satisfaction in seeing UNICEF turn toward developing the mind as well as the body of the child, and the hope that the trend would become even stronger in the future. He particularly stressed the need for training teachers of teachers.

The Board also approved projects in Chile, Costa Rica, and Haiti for vocational training for out-of-school youth, which the International Labour Organisation has helped develop. A representative from the ILO pointed out that this kind of assistance has the value of opening new horizons for those who will in the future contribute to the stronger economic and social organization of their countries.

Aid in the field of child welfare services was increased from commitments of $400,000 in 1960 to $1,500,000 in 1962. It is anticipated that this type of aid will increase to about $2.5 million in 1964.

The bulk of UNICEF aid will continue to go for the establishment of programs in the fields of health and nutrition. A total of 124 projects were approved, amounting to about $16.5 million.

A major part of the Board's discussion focused on the need for considering children in planning for national development. A report on this subject submitted by the executive director pointed out that little planning for children is being done in most developing countries, and stressed the need to recognize social development as an essential partner of economic development. Throughout the discussion, it was made clear that UNICEF is prepared to assist countries in reviewing their children's needs and in making comprehensive plans to meet them.

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The importance of close association of plans for social and economic development also received major attention at the spring meeting of the United Nations Social Commission (April 30–May 11), which passed resolutions urging, among other steps, the preparation by the Secretariat of guidelines for the use of governments for the allocation of resources to various social programs at different stages of economic development; the inclusion of social as well as economic planning in the establishment of regional development institutes; and the use of such institutes to advise governments on problems of integrating economic and social planning. The Commission also urged increased support for technical assistance projects in the field of housing and for other U.N. programs in the social field; and recommended that the Economic and Social Council set up a special committee on housing.

Child Abuse

A suggestion that the States require physicians and hospital administrators to report cases of suspected physical abuse of children by adults was made in late May by a group of lawyers, juvenile and family court judges, probation officers, doctors, and social workers, called together by the Children's Bureau to consider action to protect "battered children."

The 1-day meeting was the outgrowth of the Bureau's January 15 conference

on the abused child which recommended that legal aspects of the problem be given technical consideration. (See CHILDREN, May–June 1962, p. 123.)

A law making such reporting mandatory on physicians and hospital administrators would be helpful, the group suggested, since these professionals "are bound by law as well as by professional ethics to respect the confidentiality of the professional relationship." Such a statute, the group agreed, should relieve the doctor or hospital administrator from liability to charges of slander or libel arising from the reporting. In addition, it should specify what to report, and to whom the report should be made.

What to report, the group agreed, should probably be described in such general terms as an injury which the person making the report has reason to believe was inflicted on the child by a parent or caretaker.

Each State would have to decide for itself to whom the report should be made, the group pointed out, the majority specifying a preference for law enforcement bodies and a minority social agencies having protective functions.

A draft of a model statute embodying the proposal is now being developed by the Children's Bureau. It will be circulated for comment among members of the legal profession, law enforcement officers, pediatricians, hospital administrators, social workers, and others concerned with child health or welfare before being put in its final form.

Juvenile Delinquency

In July the President's Committee on Juvenile Delinquency and Youth Crime announced 21 grants for training personnel to prevent and treat juvenile delinquency and youth crime. Like the four training grants made previously (see CHILDREN, July–August 1962, p. 164), these grants were made to support university training centers, short-term workshops, and the development of new training materials and techniques.

The universities to receive training center grants are: the University of North Carolina, $153,744; the University of Utah, $150,000; the University of Washington, $112,488; Wayne State University, $152,201; and Western Reserve University, $151,500.

The following organizations received grants for workshops: Civic Center Clinic, Inc., Brooklyn, $800 for 10 workshops for court, probation, and parole workers, gang workers, and representatives of the Division of Vocational Rehabilitation and the New York State Employment Service; the Hunter College School of Social Work, $69,940, for a series of staff development workshops; the National Council on Crime and Delinquency, $80,470, for a series of regional institutes for parole board members; the Kings County Court, Brooklyn, $12,135, for three annual 5-day institutes for college teachers to be given experience by probation officers; the Department of Institutions, Washington State, $5,616, for a series of workshops for State youth workers; and the St. Louis University School of

PROGRESS IN REDUCING INFANT MORTALITY

Deaths under 1 year per 1,000 live births

Countries ranked on 1961 rate	1961		1950		Percent decrease since 1950
	Rank	Rate	Rank	Rate	
Netherlands	1	*15. 4	3	25. 2	38. 9
Sweden	2	*15. 5	1	21. 0	26. 2
Norway (1959)	3	18. 7 (1959)	5	28. 2	33. 7
Australia	4	19. 5	2	24. 5	20. 4
Finland	5	*19. 8	11	43. 5	54. 5
Switzerland	6	*20. 8	8	31. 2	33. 3
United Kingdom	7	22. 1	9	31. 4	29. 6
Denmark (1959)	8	22. 5 (1959)	7	30. 7	26. 7
New Zealand	9	22. 8	4	27. 6	17. 4
United States	10	*25. 3	6	29. 2	13. 4
Canada (1960)	11	27. 3 (1960)	10	41. 5	34. 2
Japan	12	28. 8	15	60. 1	52. 1
Ireland	13	30. 5	13	46. 2	34. 0
Luxembourg (1960)	14	31. 5 (1960)	12	45. 7	31. 1
Federal Republic of Germany	15	*31. 7	14	55. 6	43. 0

(*provisional)

The countries in the above table are those with populations over 300,000 which are known to use the World Health Organization definitions of live birth and of infant death, and to have relatively complete reporting.

Among these countries, the Netherlands, Sweden, and Norway now have the lowest infant mortality rates, according to the latest available figures. Only 4 of these countries had rates in 1961 under 20 per 1,000, notably the Netherlands, Sweden, Australia, and Finland. The United States, with a provisional rate of 25.3, continued to rank 10th as it has in recent years, showing a drop from the 6th place it occupied in 1950. Of countries with relatively low infant mortality rates in 1950 (under 30 per 1,000), the largest gains in percent reduction in rate by 1961 were accomplished by the Netherlands, Norway, Sweden, and Australia. Relative gains since 1950 were smallest in the United States and in New Zealand.

The provisional infant mortality rate recorded for the United States in 1961 is about 15 percent higher than the rate in the United Kingdom, and about 63 percent higher than in the Netherlands and Sweden. If the rate in the United States were no higher than in the Netherlands and Sweden, infant deaths in this country would number 42,000 fewer for the year.

The sources of the above data are the United Nations, Statistical Office, and the U.S. Department of Health, Education, and Welfare, National Vital Statistics Division.

Social Service, $84,975, for inservice training of juvenile court, probation, and parole personnel, teachers, youth counselors, and social workers; and for educational and group work services for parents of children under juvenile court supervision.

Ten grants to develop training materials went to the Citizens' Committee for Children of New York, the International Association of Chiefs of Police, and seven universities.

The committee also recently made additional grants for planning community demonstration projects to combat juvenile delinquency. These went to the Minneapolis Health and Welfare Council, $149,845; the Youth Opportunities Board of Greater Los Angeles, $252,906; the Philadelphia Council on Community Advancement, $165,000; the Chicago Commission on Youth Welfare, $292,000; the District of Columbia Board of Commissioners, $100,767; the Detroit Commission on Children and Youth, $202,200; and the Harlem Youth Opportunities Unlimited, New York, $230,000.

Radiation

Recommendations for expanding the Nation's network of radiation surveillance centers and for intensifying research and development of methods in radiation control were made by the National Advisory Council on Radiation in a report released in June by the Surgeon General of the Public Health Service.

Created in 1958 to advise the Surgeon General on control of radiation hazards, the council urged in its report the coordination of public health and related resources at the Federal, State, and local levels, for an integrated national effort.

The report points out that countermeasures developed to control environmental contamination should meet the criteria of being practical, effective, and safe; responsibility for their application should be clearly defined; and research on countermeasures should be directed to methods that improve the safety of radiation sources, control vectors of radiocontamination, and minimize or prevent harmful effects of radiocontaminants admitted to the body.

Specific countermeasures are discussed at some length in the report. Recommended for radioactive iodine, iodine 131, in the event dose levels of this product of radioactive fallout rise high enough to warrant countermeasures, is the use of powdered or evaporated milk for infants and pregnant and lactating mothers. The report describes iodine 131 as one of the most important short-lived radiocontaminants gaining entry into the human body mainly through ingestion of dairy products. It concentrates in the thyroid gland and may cause physical damage, especially to infants and young children. Countermeasures for strontium 90—long-lived and introduced into almost all kinds of food via contaminated soil—are also considered, primarily in relation to soil-content and diet changes.

Other recommendations that are set out in the report concern training radiation health specialists and expanding the Service's budget for radiological health efforts in research and development, Federal-State programs, and countermeasure activities.

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A technique for removing radioactive iodine from milk developed by radiation chemists in the laboratories of the Public Health Service was described at a meeting of the American Dairy Science Association in June at College Park, Md. The process, which has been accomplished on a laboratory scale only, involves passing raw milk through columns containing special resins that attract and hold the iodine. This is an application of a similar process using a different resin to remove radioactive strontium from milk, under development for the past few years in a joint project of the U.S. Department of Agriculture, the Public Health Service, and the Atomic Energy Commission.

The announcement of the new process, described as capable of removing 95–98 percent of radioactive iodine from fallout-contaminated milk, came shortly after reports in May that the radioactive iodine level in pasteurized milk sampled that month at Public Health Service radiation surveillance stations in 12 Midwestern States, including stations at Wichita, Kans., Kansas City, Mo., showed a sharp increase. Though these increments were believed to be transient—resulting from the Pacific atomic tests—sampling in these Midwest areas was increased from the usual weekly schedule to twice weekly. In June, sampling showed a substantial decline in most of the affected areas.

For places with the highest radiation levels, the service made plans to gather additional data. In late June, 10 children accompanied by parents were taken from Kansas City and 10 from St. Louis to the New York University-Bellevue Medical Center for studies of the amounts of radioactive iodine retained by the thyroid gland in relation to the amount they had consumed in milk (or, with the St. Louis children, in their total diet) for 10 days prior to leaving for New York. Under Public Health Service sponsorship, the children and parents, who are members of families of Federal and local health department employees, were tested with specially designed equipment for measuring low-level gamma radiation in the human body.

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According to data collected over 4 years at the University of Michigan Medical Center, to gauge the effect of radioactive fallout on the thyroid glands of unborn children, the amount of radioactive iodine in fetal thyroid glands during the 3 months, December 1958, January 1959, and May 1959, topped the "maximum permissible level" of 130 micromicrocuries ($\mu\mu$c.) without any apparent ill effects. In each of these months the level of 180 $\mu\mu$c. was reached. The concentrations fluctuated markedly from week to week during periods of bomb fallout, and varied widely from one person to another.

The medical center began work on the problem while seeking a clue to the cause of cretinism, a disorder marked by underactivity of the thyroid gland. This gland concentrates the iodine in the body and, according to the director of this study, Dr. William H. Beierwaltes, in the fetus it collects iodine more vigorously than in adults. He estimates that the fetus picks up 60 percent of the total iodine in mother and child.

Education

By July 1 of this year almost $600 million in Federal funds had been spent or obligated under the National Defense Education Act since its passage in 1958, according to figures from the Office of Education. During this time—

• About 350,000 undergraduate and graduate students borrowed some $225

million to help finance their education, of which $202 million was in Federal money. Five times the amount due on June 1, 1962, had already been repaid—a total of $5 million.

- $150 million—matched by a similar amount in State funds—went to elementary and secondary schools for strengthening instruction in science, mathematics, and modern languages; and $2.7 million to private secondary schools for the same purpose.
- $47.8 million went to school counseling and guidance testing services. Local schools are now employing nearly 22,000 full-time guidance personnel, as compared with 12,000 before passage of the act.
- $22.4 million were expended on special institutes to train personnel for professional careers in counseling and in guidance—attended by more than 11,000 persons.
- $58.6 million went to fellows and graduate schools participating in a program designed to train college teachers.

Other expenditures were made for the development of language teachers and encouragement of the study of modern languages, the training of technicians—both youth and adults—for jobs related to the national defense, research in the use of audiovisual teaching equipment, and the spread into the schools of information developed by research.

School Desegregation

How did Atlanta and Memphis desegregate their schools so smoothly and why did Little Rock and New Orleans have so much trouble?

In a recent survey of school authorities in 30 city and county school districts in 9 Southern States, conducted by the Potomac Institute, a nonprofit organization in Washington, D.C., 30 out of the 34 persons interviewed said that they would find useful the answers to this and other questions concerning the steps to successful desegregation.

The survey was undertaken to determine whether school officials (superintendents and school board chairmen), "caught in a cross current between Federal law and State resistance," want aid in solving problems of school desegregation and, if so, what kind and from whom. Of the 30 school systems, 6 already had begun desegregation, 1 was under court order to do so, 2 had cases pending in Federal court, and 21 had not yet moved toward desegregation.

Such information, the majority of the respondents said, should come from a reliable education agency and should consist of "unbiased data," not "hints or suggestions."

More than half the interviewees (56 percent) said they could make use of consultants on desegregation, and 20 (59 percent) said they thought conferences dealing with problems of school desegregation would be of value. Reporting on the survey in "School Desegregation—Help Needed?" a publication of the institute, J. Kenneth Morland asserts that all the respondents—even those in districts where no desegregation has taken place—seem resolved to accept some desegregation in order to maintain public education.

TV and Children

A series of conferences to outline research projects on the impact of television on children will be held this fall under the auspices of the Department of Health, Education, and Welfare. Educators, child welfare specialists, research workers in the field of mass communications, and representatives of the television industry are expected to participate. In addition to recommending specific research projects—of scholarly merit as well as of practical use to television programers—the conferences will plan ways of conducting this research. Among the proposed research will be projects to assist the television industry to develop techniques for use in children's programs.

A seven-member steering committee, representing the fields of child welfare, education, and television, under the chairmanship of Bernard Russell, Acting Special Assistant to the Secretary of Health, Education, and Welfare, will direct the conferences. The committee, which met first in July, will, in addition to planning the conferences, recommend research projects on the basis of the conferences' proposals, attempt to arrange financial support, and set up an appropriate mechanism for their supervision. According to the chairman, since the responsibility for determining the content of programing lies with the broadcasters, the committee does not intend to interfere with that responsibility.

The Foundation for Character Education and the Ford Foundation are contributing conference funds and services; research sponsorship or financing may come from a number of different organizations.

Smoking

The wishes of the parents have little effect upon whether or not teenagers smoke, according to a survey of 1,414 high school students conducted in Levittown, N.Y., under the supervision of the Nassau division of the American Cancer Society. The survey was conducted in two high schools by two health teachers, Emanuel Plesent and Robert Waters, under the supervision of Anthony J. Di Benedetto, supervisor of health education and recreation. The students, who answered the questions anonymously, ranged from 14 to 19 years of age.

Their answers showed that 41 percent of the teenage smokers began to smoke despite the fact that they were refused parental permission, while only 8 percent of the nonsmokers cited parental disapproval as a reason for not smoking. Sixty-nine percent of the smokers, however, reported that they had been able to win parental permission a year or more after they had begun smoking.

The survey indicated that less than one-third of the students in the two schools are smokers (32 percent), and that a higher percentage of boys (36 percent) smoke than girls (24 percent). It also showed that most smokers (78 percent) began smoking regularly before they were 15 years old. The largest number reported they began smoking at 14, while 22 percent reported that they had started smoking regularly before they were 13.

The large majority of the smokers (62 percent) gave "relaxation" as their reason for smoking, while others cited "habit" (20 percent) and "social" reasons (15 percent). The nonsmokers gave the following reasons for not smoking: "health" (50 percent), "financial" (17 percent), and "social reasons" (17 percent).

An awareness of the harmful effects of smoking was indicated by a large number of both the nonsmokers (85 percent) and the smokers (50 percent).

The survey showed no conclusive difference between smokers and nonsmokers regarding participation in after-school or community activities, but it did show that the two groups do not

tend to mix socially. Among the nonsmokers, 85 percent reported that "some, few, or none" of their friends smoked, while a majority of the smokers (59 percent) reported that "all or most" of their friends smoked.

No discernible relationship to parental smoking habits and those of the teenagers showed up in this study, a finding contrary to the results of a study made in Portland, Oreg., in 1959 which found the most important factor distinguishing "high smoking" from "low smoking" groups of students to be whether or not the parents or older siblings smoked. (See "Modifying Smoking Habits in High School Students," by Daniel Horn, CHILDREN, March–April 1960.) In the Levittown study, 79 percent of both smokers and nonsmokers reported that one or both parents smoked.

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The Public Health Service is setting up a panel of advisers to study the evidence from research on the impact of smoking on health, to evaluate this evidence, and make appropriate recommendations. The group will be selected by the Surgeon General after consultation with representatives of interested Federal agencies, professional groups, health organizations, and the tobacco industry.

Health Research

A national conference on research methodology and potential in community health and preventive medicine will be held in New York City, December 5–7, under the sponsorship of the Council on Research of the American College of Preventive Medicine and the New York Academy of Sciences. Cooperating organizations are the Children's Bureau, the Public Health Service, the American Public Health Association, the Aerospace Medical Association, the Armed Forces Epidemiological Board, the Industrial Medical Association, the American Academy of Occupational Medicine, the Association of State and Territorial Health Officers, and the American Association of Public Health Physicians.

Designed for community health agencies, the conference will emphasize methodology rather than the findings of studies, with major attention given to research in chronic disease, mental health, and accidents; evaluation of programs; operational research; and the development of a research climate. Illustrative studies will be drawn from local and State health department experiences as well as from industry and aerospace medicine.

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A clinical research center in which premature infants will be studied for clues to basic biochemical physiological processes of human growth is soon to be established at the Stanford University Medical Center. The research, which will focus on a unit of six bassinets, is financed by a grant of $267,305 from the National Institutes of Health. This was 1 of the 10 grants made by the Institutes in June under a program begun in 1960 in which awards are made to medical schools and research hospitals for setting up centers of general clinical research on man and his diseases. The Stanford project is the first in this program to concentrate on problems of diseases in premature babies.

Another grant of the same series gave $285,000 to the Children's Hospital of Pittsburgh for initiating a clinical research center focusing on children's diseases.

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The development of a method that has pinpointed the cause of one form of thrombocytopenic purpura, occurring in newborn infants, was announced recently by the National Institute of Arthritis and Metabolic Diseases, Public Health Service. This serious blood disease, comparable in some ways to that arising from the Rh factor in red blood cells, is uncommon and therefore is rarely recognized. It is characterized by bleeding caused by a lack of blood platelets—elements in the blood which prevent leakage of blood through the vessel walls.

According to the Institute, investigations have confirmed the long-suspected fact that most cases of infant purpura are due to antibodies formed in the expectant mother against a different type of platelet in the unborn child, whose platelet type is inherited from the father. The mother's antibodies are transmitted to the infant through the placenta, destroying his platelets and thus causing bleeding. The Institute's scientists noted that platelet mismatching can also occur in blood transfusions.

The new technique, for platelet-antibody detection, is based on complement fixation, a complex process involving measurement of the substance in blood called complement, which attaches to combinations of antigen and antibody, reflecting the degree of antigen-antibody reaction.

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A California study of almost 5 years' duration that has been focusing on maternal deaths occurring within 90 days after termination of pregnancy has found that more than 100 out of 515 deaths reviewed thus far were attributable to abortion, and that of these at least 70 percent were criminally or self-induced. Maternal deaths reported from all causes totaled 725 during the period of the study, which is being conducted by the State medical association and public health department.

Other preliminary findings were that almost two-thirds of the women who died as a result of abortion were married; 15 percent had never married; the rest were widowed, separated, divorced, or with marital status unknown. Almost 30 percent had had five or more pregnancies and less than 15 percent had never before been pregnant. Almost half were 30 years of age or older.

The State department of public health is planning to publish in the near future a detailed report on abortion deaths.

Personnel

A substantial untapped resource to help meet the shortage of fully trained social workers may exist among social workers who are outside of the labor force because of family responsibilities, according to findings of research carried out by nine students of the Howard University School of Social Work.

The study, which was completed in the spring, examined some of the practices, policies, attitudes, and experiences of private social agencies in hiring and employing married female social workers with minor children. The investigators gathered and analyzed responses to questionnaires from some 300 private social agencies—affiliates of the Family Service Association of America and the Child Welfare League of America—in 45 States.

The findings revealed almost unanimous agreement among the agencies that the child care plan made by the mother was a major factor in determining whether or not she would be hired. Many social agencies reported that they considered social workers

who are mothers of small children to be valuable workers, but a significant minority expressed the opinion that the part-time status and family responsibilities reduced their effectiveness. In regard to the adaptation of personnel policies and practices to facilitate employment of such social workers, by allowing them to work less than a full day, at irregular hours, or less than a full week, the majority of the agencies expressed a preference for the last arrangement.

There was also more readiness to limit rather than to eliminate night and weekend work for these employees, the demand for this kind of work appearing to be greater the larger the agency.

Nutrition Program

On the basis of studies of the nutritional status of children seen in its health programs, the American Joint Distribution Committee, a voluntary agency operating health and welfare programs in Jewish communities in 27 countries including Morocco, Tunisia, and Iran, has broadened its efforts to improve the nutrition of children in these three countries. In addition to nutrition education efforts in health centers, schools, and community development projects, the program includes five forms of supplementary feeding. These are:

1. The distribution of milk for newborns and infants, supplied in various reconstituted forms through a series of milk stations.

2. The distribution to expectant or lactating mothers of food parcels designed to provide a satisfactory intake of protein, iron, and vitamins.

3. The provision to preschool and school children of at least one hot meal a day, through school canteens. These meals are designed for various age groups of children to provide two-thirds of their caloric requirements and, as nearly as possible, their total requirements of animal protein, calcium, and vitamins.

4. Distribution to families of food parcels designed to supplement their protein and fat intake.

5. Soup kitchens and communal canteens for destitute persons.

Some 63,000 people are receiving food through this program at a yearly operating cost to the Joint Distribution Committee of $600,000. Important in the program, the agency reports, are the surplus commodities donated by the U.S. Department of Agriculture. At present the agency is studying the ways of using fish flour, possibly on a 4-percent basis in a mixture for bread, as an inexpensive, easily transportable source of protein.

The program is supervised by four nutritionists in the field and three physicians and a nutrition consultant at the agency's European headquarters in Geneva.

Among the studies which influenced the nature of the program was one which compared the weight and dietary patterns of Iranian-Jewish infants with those of a group of infants studied in England and Wales. The study showed that at birth the weights of the two groups of children were similar, the British babies being on the average only 0.5 of a kilogram heavier, but after 2 years the British children were on the average 2.9 kilograms heavier than the Iranian children.

Health Services

The creation of a National Commission on Community Health Services, to conduct a 4-year study of community health needs and services, was announced in May by the cosponsors, the American Public Health Association and the National Health Council. During the first 2 years, the commission will supervise a number of local and national studies of health services.

The community studies will be carried out in selected areas under local leadership from the fields of health, education, and welfare, industry and business, and representatives of the public. Each community will study its own health problems, following prepared study guides, questionnaires, and consultation provided by the commission. Study content will include health problems, program resources, trends, use of knowledge, and attitudes toward health and health services.

The national study will involve task forces of three to five specialists each, which will prepare reports on assigned subjects, using materials brought together by the staff.

The activities of the commission will culminate in a national conference to discuss prepared reports based on the community study reports and task force reports. The conference will make recommendations for implementation within the following 2 years.

The program will be financed chiefly by philanthropic foundations, particularly the Kellogg Foundation, and by the Public Health Service.

Aid to the Unemployed

Only 15 of the 50 States participated in the Federal program of aid to dependent children of unemployed parents in the first year of its operation. These were Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Utah, Washington, and West Virginia.

Three out of every five applicants approved for aid in the program in the first 10 months of its operation were not receiving any help from local general assistance programs, and in two-thirds of the approved cases the unemployed fathers had no claims pending for unemployment compensation, according to an analysis made by the Bureau of Family Services of statistics from 14 of the States. In 47 percent of the cases the unemployed fathers were either ineligible for compensation or had exhausted their benefits more than 6 months before their applications for aid.

During the first 10 months of the program there were 123,987 applicants for aid under the program, with 93,547 approved for assistance; 36,660 cases were closed, two-thirds of them when the father returned to work. Only 2 percent were closed because the parent refused to accept offered employment.

Vital Statistics

Live births in 1961 numbered 4,282,000, which results in a birth rate slightly below the 1960 and 1959 rates, according to provisional statistics released in April by the Public Health Service. The relative stability of the birth rate, according to the Service, is likely to continue for a few years until the girls born in the bumper baby crops of 1946 and succeeding years reach childbearing age. Currently, the fertility rate is fairly steady at about 120 live births per 1,000 women in the childbearing ages.

The 1961 provisional infant mortality rate of 25.3 deaths under 1 year of age per 1,000 live births sets a new low record, the previous low occurring in 1960 with a rate of 25.7.

IN THE JOURNALS

Paternal Deprivation

Nineteen cases of children diagnosed in a pediatric clinic as suffering from a disturbance in the father-son relationship are reported in the July 1962 issue of *Pediatrics*. ("Paternal Deprivation—A Disturbance in Fathering," by Morris Green and Patricia Beall, pediatrician and social worker in the Department of Pediatrics, Indiana University School of Medicine.) The authors report that the patients, all boys between the ages of 4–15, presented a variety of behavior symptoms, including under-achievement in school, nervousness, fearfulness, depression, excessive daydreaming, and effeminate behavior, and such physical symptoms as obesity, headaches, ulcerative colitis, recurrent vomiting, tics, and enuresis.

On the basis of interviews with the father, mother, and child, the clinic found the fathers could be characterized in one of five ways: (1) the father who is unable to give emotionally to his child; (2) the father who does not know how to relate to a growing boy; (3) the noncommunicative father who is merely a "spectator" in the home; (4) the "married bachelor" still tied to his own mother's apron strings; and (5) the father who is disappointed in his son.

In most instances, the authors report, the mother tended unconsciously to encourage the father's aloofness.

The clinic in every instance stressed the importance of seeing the father and in all but five cases succeeded in this. Case management included a series of interviews with the child and his parents conducted by the pediatric resident and the medical social worker—except in those instances in which referral was made to appropriate facilities for intensive psychotherapy. The goal was to bring the father closer to the child—spatially and psychologically—and this was achieved to an appreciable degree in 11 cases, the authors report.

Cases in which the disturbed relationship arose chiefly from an imbalance in the interdependent roles of mothers and fathers achieved the most dramatic responses, according to the authors; while cases characterized by psychological immaturity of one or both parents responded poorly to treatment.

Planning for Children

In an article in the July 1962 issue of the quarterly, *Social Work*, Alfred J. Kahn, professor at the New York School of Social Work, calls on experienced practitioners and administrators to consider a number of "child welfare planning hypotheses" to attack "an urban child care crisis of considerable size" in the United States today. ("The Social Scene and the Planning of Services for Children.") Pointing out that life in the modern city creates "high-hazard groups," the author presents social trend data and evidence from a variety of child welfare studies to support his contention that the protection of children in our cities today requires:

- A much larger "institutional or developmental" emphasis in child care, including the provision of such services as day care, home help, family life education, and vocational counseling.
- Early evaluation and planning in individual cases involving family and child problems in a context organized to avoid the bias of the precommitted practitioner or agency.
- The availability in the community of a full range of services for maintaining minimum health and living standards and to protect family life, underpinned by a comprehensive and adequate public social service system.
- Overall coordination of functions and programs of service agencies and, in the specific case, integration of service and intervention.
- The establishment of mechanisms for accountability for competent planning and followthrough in individual cases where there has been community intervention.

"It means little," maintains the author, "to develop qualified foster home placement or residential treatment centers in communities which lack basic assistance programs and the related family casework or child welfare services to children in their own homes."

Foster Parents Are People

With the majority of children coming into foster care today as a result of family breakdown, the purpose of foster placement is to provide a therapeutic and rehabilitative experience for child and parent, say Nina Beck Tegethoff and Harriet Goldstein in the June 1962 issue of *Child Welfare*. ("A Realistic Appraisal of Homefinding.") At the same time, they point out, the availability of couples who can live up to the social worker's image of ideal foster parents is increasingly limited because foster parents "live in the same world as all parents" and are subject to the same pressures and anxieties as everyone else today. This means, say the authors, that child placement agencies must learn to use selectively as foster parents couples who, despite their weaknesses, have strengths as individuals and as a family unit which can be beneficial to particular children.

Maintaining that the risks of placement away from home must, like surgery, sometimes be undertaken to remedy a serious situation, the authors assert that the agency must be ready to invest in the treatment of child, parents, and foster parents; and that in respect to foster parents the investment must be to regard them as "semiprofessionals" to be stimulated by programs of on-the-job training and by financial compensation for service in addition to maintenance costs.

The authors also maintain that agencies should be ready to supplement their foster family resources with other kinds of settings for meeting children's needs, including agency-sponsored group homes, residences, or institutions.

The authors are, respectively, former casework supervisor and present group home specialist at the Association for Jewish Children, Philadelphia.

The Subtle Impact of TV

The conclusion that standards of good taste and judgment for television shows watched by children need to be applied at points of program origin, because of factors interfering with

parents' ability and motivation in this area, was drawn from a study of the views of 99 Chicago mothers on the influence that television has on their children. Described in the quarterly *Child Development* for June 1962 ("Parents' Views of the Effect of Television on Their Children," by Robert D. Hess and Harriet Goldman) by two members of the Committee of Human Development of the University of Chicago, the study indicated that these mothers were generally not concerned about the cumulative effects of television. They reportedly believed that television can have both good and bad effects—can keep the child quiet but can promote passivity—and that the networks and stations have "basic standards of good intentions toward the child viewer."

Though the mothers almost unanimously expressed the belief that parents responsibly supervise their children's TV viewing, the majority actually made little effort to give this supervision, according to the investigators, yet saw themselves as the most competent authorities for evaluating program content. The findings showed no difference in social class, except in the tendency to maintain that the content was supervised. Acknowledging the difficulty of measuring the subtle, gradual impact of television on children, the authors suggest that there is need for a public concept of television as a source of mediocrity which "hinders the full development of the child's mental and emotional faculties." They also suggest that schools and churches play a greater role in evaluating program content.

Maternity Care

Child and Family for July 1962 describes the difficulties encountered at St. Mary's Hospital in Evansville, Ind., after the introduction of a "family-centered" maternity care program and how these were overcome. ("An Obstetrician's View of Family-Centered Maternity Care," by Edgar L. Engel.) The chief aspect of this program is in giving the care of the baby to the mother from birth by leaving the baby by her bedside rather than in a nursery for newborns. When the program was first introduced, visiting was restricted to the father only, who could visit at any time of the day and was even welcome in the delivery room.

According to the author, who is head of the hospital's department of obstetrics and gynecology, the maternity division's census of patients unexpectedly declined in the months following the introduction of the program, but this trend was reversed after standard hospital visiting privileges were extended to the division—the infants being removed to nurseries when visitors were present. At the same time the hospital placed renewed emphasis on an educational program for personnel and the public as to the advantages of the program. These advantages are identified by the author as:

- An apparent decrease in the spread of infectious diseases brought into the maternity ward.
- More immediate attention to the infant's individual needs.
- The stimulation of a natural mother-offspring relationship.
- Increased opportunity for the mother to learn how to care for her baby while in the hospital.
- Activity of the father in supporting the mother in labor, resulting in a sharp reduction in the mother's need for analgesia and anesthesia, and an earlier acquaintance of the father with his child.

The article first appeared in the *Hospital Progress* series issued by the Hospital Association, St. Louis, Mo.

Battered Children

Describing the "battered-child syndrome" in the July 7, 1962, issue of the *Journal of the American Medical Association*, a pediatrician, a psychiatrist, an obstetrician, and a radiologist point to the importance of complete skeletal X-rays of every child presenting insufficiently explained injuries in order to determine whether there are evidences of past repetitive trauma and thus of deliberate child abuse. ("The Battered-Child Syndrome," by C. Henry Kempe, Frederic N. Silverman, Brandt F. Steele, William Droegemueller, and Henry K. Silver.)

The authors report that in a survey of 71 hospitals across the country, they found that 302 such cases had been identified during one year and that 33 of the children had died and 85 suffered permanent brain injury.

The battered-child syndrome is seen among children of all ages, report the authors, but most commonly among children under 3. Beating of children, they assert, is not confined to adults of psychopathic personality or of borderline socioeconomic status, though in all abusive parents there is a "defect in character structure which allows aggressive impulses to be expressed too freely" and in many "some suggestion that the attacking parent was subjected to similar abuse in childhood."

Pointing out that physicians have great difficulty in believing that parents would attack their children and in questioning them about it, the authors maintain that physicians are nevertheless responsible for initiating a complete investigation when symptoms of abuse are evident. Both physicians and hospitals have an obligation to report such cases to the police department or a special children's protective service, they assert, maintaining that a battered child should not be returned from the hospital to his own home even if the risk of repeated assault is only moderate.

Bad or Sick?

To ask whether a juvenile delinquent is "sick" or "bad" signifies the kind of "schizophrenic thinking" that blocks understanding and treatment of the delinquent, according to an article in the April issue of *Social Work* ("Juvenile Delinquents: Sick or Bad," by Seymour L. Halleck.) By very definition, states the author, the delinquent's behavior is bad. Delinquents are "sick," he adds, only if sickness is not conceived of as the result of external factors acting upon a passive individual, but rather as a personal vulnerability to stress.

To treat delinquents as not responsible for their behavior, the author asserts, is to encourage passivity and inadequacy. But to become engrossed in the "meaningless" concept of bad *versus* sick, he maintains, ignores the most important element in treatment—recognition of "the complex interplay of many causative factors" behind the delinquent behavior. His recommendation for an effective attack on delinquency is to try not only to modify the etiological factors in the external environment but to treat the "festering sores" of personality distortions within the individual—and avoid preoccupation with "badness, responsibility, or sickness."

The author is chief of psychiatric services in the Division of Corrections of the Wisconsin State Department of Public Welfare.

READERS' EXCHANGE

LOVATT: *Autistic children*

Margaret Lovatt's article, "Autistic Children in a Day Nursery," in the May–June 1962 issue of CHILDREN, is an excellent report of a venturesome service to the preschool schizophrenic child with autism. There is for me a personal gratification in learning of any new application of concepts which have been identified with the part of my work which was concerned with study of, and planning for, just such children. Many of my experimental approaches were, and often continue to be viewed as so controversial, that there has not been sufficient and varied testing over a period of time in different localities.

The Toronto experience described by Miss Lovatt might serve as a model for a program for the study and care of autistic schizophrenic children, who traditionally have been so unresponsive and therefore so frustrating to psychiatrists, psychotherapists, teachers, and parents who have tried to reach them.

No dramatic successes are claimed in Miss Lovatt's article, but there is a calm assumption that 2 years of the program with children who started at the age of 3 or 4 years would result in their placement in kindergarten or in the first or second grade with normal children. There is a healthy absence of any note of despair or demand for unending singleminded dedication of therapists and parents to the sick child without regard for the other normal demands of life and society. Instead, there is the emphasis on new or different approaches to meet the needs of the child, the family, and the service.

The realistic and truly experimental approach described by Miss Lovatt would seem to be the best safeguard against mutual rejection between autistic children and the therapeutic program, or between the parents of autistic children and the program.

An experimental approach must also be taken in working with the parents of these children and should be regarded, as it was in this program, as an integral part of the whole program with the ever-present recognition of the aim: to help parents face realistically the limitations, problems, and opportunities for their deviant child in terms of the present, including the chance to enjoy their childhood, and of the future, whatever it may bring, and not in terms of the parents' past failures.

Lauretta Bender, M.D.
Director of Psychiatric Research, Children's Unit, Creedmoor State Hospital, Queens Village, N.Y.

JOHNSON: *Nursing sick children*

As Dorothy Johnson indicates in her timely article, "Professional Education for Pediatric Nursing" [CHILDREN, July–August 1962], the quality of nursing care of children will be distinctly better in hospital units where the charge nurse is a well-prepared specialist whose main concern is patient care rather than an administrator who spends her time at a desk overwhelmed by paperwork. Such a nurse will know each child and each family. She will be able to interpret individual needs to all levels of personnel in the unit. She will be able to coordinate and promote the care provided by doctors, therapists, and members of other related disciplines. She will be secure enough to support the parents during periods of crisis.

Nurses have only begun to offer this kind of comprehensive care to sick children, not because of lack of interest, but because of inadequate understanding of what being ill means to a child. The impact of illness on an infant or child is quite different than it is on an adult, primarily because the child's growth needs make him more vulnerable to added stress. His reaction is more violent because his defenses are poorly developed. He needs help from meaningful adults, specifically his parents, in order to cope with the experience satisfactorily. If he does not get this help, the unresolved experience may leave him more vulnerable to other stresses of life.

A child's illness is a terrifying experience to his parents. They too need support—to be able to stay with the sick child, to understand the changes in behavior which illness brings, and to be able to verbalize their anxieties about their own child as well as other children they see in the hospital.

Florence Erickson
Professor of Pediatric Nursing, School of Nursing, University of Pittsburgh.

FRONTISPIECE: *Childhood's wonder*

I was so impressed by the frontispiece of the May–June 1962 issue of CHILDREN [see cut below], I couldn't help writing this sonnet:

"REGARD AND WONDER"
(Habakkuk 1:5)

A people sat in darkness, saw great light;
This boy: four years of silence, hears great sound.
Who felt the greater ecstasy, delight
At joys undreamed of and now newly found?
No Roentgen, Bell, Marconi ever knew
More rapture, wonder, as the once unknown
Became the known under his hand and view.
In this bright instant four dark years have flown.
A de profundis! Out of the depths, come! come!
A-boom! a-boom! trembles through hand and ears,
As Jim, his deaf friend beats upon that drum,
And with responsive palm his friend Sue "hears."
Don't pity these whose world's so deeply still:
They too know childhood's wonder and its thrill.

Park J. White, M.D.
St. Louis, Mo.

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CASEWORK SERVICES IN PUBLIC ASSISTANCE MEDICAL CARE. Sarah A. Butts. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Family Services. 1962. 110 pp. 50 cents.

Directed to public assistance caseworkers, this publication discusses the needs of public assistance recipients who are physically ill and the caseworkers' responsibilities in helping them to utilize medical care provisions offered by the State and community.

RESEARCH RELATING TO JUVENILE DELINQUENTS. No. 2 of a series, Research Relating to Special Groups of Children. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 100 pp. 35 cents.

A total of 477 research projects on juvenile delinquency reported to the Children's Bureau Clearinghouse for Research in Child Life since 1948 are listed in this publication together with pertinent data reflecting the main trends in each research area.

SERVICES IN PUBLIC AND VOLUNTARY CHILD WELFARE PROGRAMS. Helen R. Jeter. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 396. 1962. 126 pp. 40 cents.

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